CARNEGIE DENTAL

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Welcome to Carnegie Dental! Please take a few moments to complete this form to the best of your ability. Please don't hesitate to ask if you have any questions.

Patient Information

Name (First) *(Last)* *Birthday (d/m/y)*

Address (Number, Street) *City, Postal Code*

Home Phone *Cell Phone* *Work Phone*

Email Address *Who referred you to us?*

Emergency Contact Name *Emergency Contact Phone #*

How would you like to be contacted?

◯ Phone Call ◯ Email ◯ Text

Primary Insurance

Name of Policy Holder (First, Last) *Birthday of Policy Holder (d/m/y)*

Insurance Company *Employer*

Group/ Plan # *Plan Identification or Certificate #*

✓ *Please provide us with a detailed copy of your primary insurance information (card).*

Secondary Insurance

Name of Policy Holder (First, Last) *Birthday of Policy Holder (d/m/y)*

Insurance Company *Employer*

Group/ Plan # *Plan Identification or Certificate #*

✓ *Please provide us with a detailed copy of your primary insurance information (card).*

Former Dentist *Approx. Date of Last Dental Exam & X-Rays* *How do you feel about the appearance of your teeth?*

Physician Contact (Name & Phone #) *Date of Last Medical Exam*

Please fill out the other side as well

Dental History

*Please indicate **Yes** or **No** to the following:*	YES	NO
Have you ever had an unfavourable dental experience?	○	○
Had any trouble getting numb or with local anesthetic?	○	○
Do your gums bleed or painful when brushing or flossing?	○	○
Have you had any cavities within the past 3 years?	○	○
Do you avoid brushing any part of your mouth?	○	○
Do you have any difficulty chewing harder foods?	○	○
Do you grind or clench your teeth during the day?	○	○
Had any complications from past dental treatment?	○	○
Have you ever had/ worn a night guard?	○	○

How nervous are you about seeing the Dentist? (Please Circle)

0 1 2 3 4 5 6 7 8 9 10

	YES	NO
Past history or braces or orthodontic treatment?	○	○
Any sensitivity to hot, cold, biting or sweets?	○	○
Do you frequently get food caught between teeth?	○	○
Do you chew ice, bite your nails or any other habits?	○	○
Do you like the appearance of your teeth?	○	○
Have you ever bleached or whitened your teeth?	○	○

Medical History

Do you have OR Have you ever had;	YES	NO
hospitalization for illness or injury _____	○	○
heart problems, or cardiac stent within the last 6 months	○	○
history of infective endocarditis	○	○
artificial heart valve, repaired heart defect (PFO)	○	○
pacemaker or implantable defibrillator	○	○
orthopedic implant (joint replacement) _____	○	○
rheumatic or scarlet Fever	○	○
chronic ear infections, tuberculosis, measles, chicken pox	○	○
breathing or sleep problems (sleep apnea, snoring, sinus)	○	○
liver disease, Jaundice	○	○
hormone deficiency	○	○
diabetes – Type: _____	○	○
digestive or eating disorders (celiac, gastric reflux)	○	○
arthritis	○	○
glaucoma	○	○
epilepsy, seizures	○	○
viral infections and cold sores	○	○
hives, skin rash, hay fever	○	○

	YES	NO
pneumonia, Emphysema, shortness of breath, Scaroidosis	○	○
asthma	○	○
kidney disease	○	○
thyroid, parathyroid disease, or calcium deficiency	○	○
high cholesterol or taking statin drugs	○	○
stomach or duodenal ulcer	○	○
osteoporosis/ osteopenia (i.e. taking biophosphonates)	○	○
autoimmune disease – Type: _____	○	○
head or neck injuries	○	○
neurologic disorders	○	○
any lumps or swelling in the mouth	○	○
STI/STD/HPV	○	○
HIV/ AIDS	○	○
radiation therapy	○	○
using tobacco, marijuana or use(d) a vape	○	○
chemotherapy, immunosuppressive medication	○	○
tumor, abnormal growth	○	○
hepatitis – Type: _____	○	○

Are You;	YES	NO
presently being treated for any other illness _____	○	○
aware of a change with your health in the last 24 hours	○	○
taking medication for weight management	○	○
taking dietary supplements	○	○
often exhausted or fatigued	○	○
experiencing frequent headaches	○	○
currently pregnant or nursing (circle which)	○	○

Any allergic or bad reaction to any of the following:

○ asprin	○ ibprophen	○ acetaminophen
○ codeine	○ penicillin	○ erythromycin
○ tetracycline	○ sulfa	○ chlorhexidine (CHX)
○ latex	○ fluoride	○ metals (gold, nickel)

○ nuts _____

○ fruit _____

○ other _____

List of Medications;

Drug	Purpose	Drug	Purpose

Authorization

I understand this information to be accurate to the best of my knowledge and it is my responsibility to inform this office of any changes to my medical status.
I understand that this information will be used by my dentist to help determine appropriate dental care.
I authorize my dentist to release any information (including diagnostics, diagnosis, and record of treatment) contained in claims in order to secure the payment of benefits.
I hereby assign my dental benefits, payable from claims submitted, to my dentist, and authorize payment directly to my dentist.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I understand that payment is due when service is rendered.
I understand that "assignment" (my insurance paying my dentist directly for treatment) is accepted as a courtesy.
I understand that missed or cancelled appointments are subject to a short notice fee unless two (2) business days' notice is given.

Signature *Date*

_____ _____

I grant permission to Carnegie Dental to use images and/ or (eg. X-rays, photos including teeth/jaw/cheek) on social media pages (Website,Facebook, Instagram. I understand that these images and/ or videos wi will not be used for any other commercial purpose. *Initial:* _____

Doctor Signature: _____

ASA_____ (1-6)