**Welcome to Dolce Dental**

Personal information collected here is limited to providing patient care and receiving payment for these services. Personal information will not be used, disclosed or retained for purposes other than those identified above and will only be retained for as long as necessary to fulfill those purposes or as required by law.

Name:(Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Middle)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Numbers: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and Postal Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you prefer to be contacted for your appointment? (please circle) Phone Email Both

How did you hear about Dolce Dental?

Location\_\_\_\_\_\_Internet\_\_\_\_\_\_Referral from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**:Self\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_Child\_\_\_\_\_\_\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group/Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_Certificate# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**:Self\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_Child\_\_\_\_\_\_\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group/Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_Certificate# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Covid-19 Screening**

|  |  |  |
| --- | --- | --- |
|  |  | |
| 1. Do you have a fever or have felt hot or feverish anytime in the last two weeks?   Patient temperature at appointment: \_\_\_\_\_\_\_\_. If elevated, provide mask to patient. | YES | NO |
| 1. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip? | YES | NO |
| 1. Have you experienced a recent loss of smell or taste? | YES | NO |
| 1. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19? | YES | NO |
| 1. Have you returned from travel outside of Canada in the last 14 days? | YES | NO |
| 1. Have you returned from travel within Canada from a location known affected with COVID-19? | YES | NO |
| 1. Is your workplace considered high risk? | YES | NO |
| **Patient Vulnerability** |  |  |
| Are you over the age of 70? | YES | NO |
| Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder? | YES | NO |

**Medical History**

**Today’s date**……………………………………….....................

Have you had a medical examination within the last year?................................................................................Yes No

Are you presently under the care of a physician or specialist?..........................................................................Yes No

Have your ever required surgery, hospitalization, or extensive medical care?

Please Specify…………………………………………………………………………………………………………………………………………………………………………………………

Have you ever had any of the following medical conditions?(please circle and elaborate as necessary)

Allergies Drug Addiction Hepatitis Rheumatic Fever

Angina Epilepsy High/low Blood Pressure Stomach Disease

Arthritis Emphysema Jaundice Stroke

Asthma Heart Disease Kidney Disease Thyroid Disease

Cancer Heart Murmur Lung Disease Tuberculosis

Diabetes Hemophilia Mental/Anxiety Disorder Venereal Disease(STI)

Additional health conditions not mentioned above………………………………………………………………………………….......................

Please list all prescription, non-prescription medications/drugs or herbal supplements you are presently taking, or have recently taken:……………………………………………………………………………………………………………………………..................

Do you have allergies or adverse reactions to any drugs, medications, or local anaesthesia?.......Yes No

Please Specify…………………………………………………………………………………………………………………………………………………………………………………………….

Do you have allergies to **latex**?…………………….……………..**metal**?………………………………….**food**?………………………………………

Have you ever had **asthma**?............................ **hay fever**?........................... **hives** or **skin rash**?......................................

Are you a smoker?....................................................................................................................................................................Yes No

Do you bruise easily or bleed abnormally?..................................................................................................................Yes No

Have you ever had any injury, surgery, or radiation therapy to your face?..................................................Yes No

Have you ever been treated for or had any indications of AIDS, HIV infection, or any other disorder to the immune system?.......................................................................................................................................................................Yes No

Do you have anxiety attacks?.............................................................................................................................................Yes No

Do you have any artificial joints, heart valves, or pacemaker?..........................................................................Yes No

**Women Only**

Are you pregnant?(If so, how far along?)……………………………………………………………………………………………………....Yes No

**DENTAL HISTORY**

Is there a specific problem that you would like to have taken care of as soon as possible?.............Yes No

Please specify……………………………………………………………………………………………………………………………………………………………………………………………..

Are you happy with your teeth?..........................................................................................................................................Yes No

If not, how can we help you?........................................................................................................................................................................................

When was your last dental visit?..........................................................................................................................................................

Do you visit the dentist regularly for checkups and cleanings?(how often)………………………………………..Yes No

How often do you brush?.........................................................................floss?...................................................................................

Have you experienced any growth or sore spots in your mouth?...................................................................Yes No

Are your teeth sensitive to **cold?**…………………….**hot?**……………………….**sweets?**………………………**biting?**…………….………….

What is your sugar intake? **Low**……………………………..**medium**…………………………………….**high**…………………………………….….

Do you have any dental anxiety or have had an upsetting experience at a dental office?.................Yes No

Please specify…………………………………………………………………………………………………………………………………………………………………………………………

Do you want your teeth to be brighter?..........................................................................................................................Yes No

Do you clench or grind your teeth either at night or during the day?.............................................................Yes No

Do you snore or have sleep apnea?................................................................................................................................Yes No

Do you experience chronic pain in your jaw, neck, or shoulders?...................................................................Yes No

Does your jaw crack, pop, or hurt when opening wide?.......................................................................................Yes No

Have you ever been advised to take antibiotics before dental treatment?..................................................Yes No

Have you had any oral surgery?........................................................................................................................................Yes No

***To ensure the accuracy of the personal information, our office encourages patients and staff to maintain records that are accurate and up-to-date. Patients can notify staff on their next visit or contact the office immediately if there are changes. We also request the courtesy of 48 hours for the cancellation of an appointment, otherwise a fee of $50 will be charged.***

This is to certify that I, the undersigned, understand the necessity for the collection of personal information that I have provided in order to be delivered safe and appropriate dental treatment, and that I will assume responsibility for any fees for treatments I accept and receive, or for missed appointments.

Date………………………………………………………………………………………….………

Signature………………………………………………………………………………………….