



### New Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Gender: \_\_\_\_\_ Family Status (Married, Common-law, Single, Child): \_\_\_\_\_

Saskatchewan Health #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street

Apartment #

City

Province

Postal Code

Email Address \_\_\_\_\_ Preferred contact method:  Home  Work  Cell  Email

Do you have insurance coverage?  Yes  No If you answered No please proceed to page 2 Health Information

Is your insurance coverage:  Family Health Benefits  Social Assistance  Indian Affairs

Please bring your Saskatchewan Health Card/Social Assistance Card/Treaty# to your appointment. Please proceed to Page 2 Health Information.

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City Province Postal Code

Insured's Employer Name: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City Province Postal Code

Insured's Employer Name: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

### Responsible Party Information

The following is for:  the person responsible for payment  the parent or guardian

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Male  Female Relationship to patient  Mother  Father  Spouse  Other \_\_\_\_\_

If different from the above information:

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Fainting                             | <input type="checkbox"/> Nervous Disorders           | <input type="checkbox"/> Tumors                       |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Glaucoma                             | <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Hay Fever                            | <input type="checkbox"/> Pregnancy                   | <input type="checkbox"/> Venereal Disease             |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Head Injuries                        | Due date: _____                                      | <input type="checkbox"/> Codeine Allergy              |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Heart Disease                        | <input type="checkbox"/> Radiation Treatment         | <input type="checkbox"/> Penicillin Allergy           |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> History of infective<br>endocarditis | <input type="checkbox"/> Respiratory Problems        | <input type="checkbox"/> Prosthetic Cardiac<br>Valves |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Hepatitis                            | <input type="checkbox"/> Congenital Heart<br>Disease | OTHER:  |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> High Blood Pressure                  | <input type="checkbox"/> Rheumatism                  | <input type="checkbox"/> _____                        |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Jaundice                             | <input type="checkbox"/> Sinus Problems              | <input type="checkbox"/> _____                        |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Kidney Disease                       | <input type="checkbox"/> Stomach Problems            |   |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Liver Disease                        | <input type="checkbox"/> Stroke                      |   |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders                     | <input type="checkbox"/> Tuberculosis                |   |

• Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_

Signature of patient, parent or guardian

### MEDICATIONS

Please list any medications you are taking, ex.) prescription, herbal, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke or chew tobacco? Yes \_\_\_\_ No \_\_\_\_ If yes how often?

\_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

### **Privacy Policy**

I consent to the collection, use and disclosure of my personal information for the following purposes:

- To provide me with dental health services;
- To maintain communications and provide me with information and follow up respecting my dental care;
- To obtain payment of your account;
- For the uses, purposes and disclosures described in the Privacy Policy; and
- Other \_\_\_\_\_

