

# DaVinci Dental Services

Welcome to our office! To assist us in serving you, please complete the following confidential form. This information is important to your dental health

## Patient Information

Patient name: \_\_\_\_\_ Preferred name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Title:  Mr  Mrs  Ms  Dr Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postcode: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email address: \_\_\_\_\_  
Whom may we thank you for referring you to our office? \_\_\_\_\_  
Please tell us the name and number of your emergency contact: \_\_\_\_\_  
Please tell us the reason for your visit today: \_\_\_\_\_  
Is there anything you would like to change about your smile? \_\_\_\_\_

## Dental Insurance Information

Insured's name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_  
Group# \_\_\_\_\_  
Certificate# \_\_\_\_\_

I authorize DaVinci Dental to bill my insurance company on my behalf and assign all benefits to Dr Aleesha Maybury

## If patient is a child:

Mother's name: \_\_\_\_\_  
Work phone: \_\_\_\_\_  
Father's name: \_\_\_\_\_  
Work phone: \_\_\_\_\_  
Child's nickname: \_\_\_\_\_  
School: \_\_\_\_\_  
Pets: \_\_\_\_\_

## Dental History

Please check all that apply: Do you have or ever had the following?:

- |  |   |
|--|---|
| <input type="radio"/> Bleeding gums                  | <input type="radio"/> Swelling/sores in the mouth |
| <input type="radio"/> Biting Cheeks or Lips          | <input type="radio"/> Clicking or popping jaw     |
| <input type="radio"/> Pain in jaw joints             | <input type="radio"/> Clenching or grinding       |
| <input type="radio"/> Smoke cigarette, pipe, cigar   | <input type="radio"/> Chew tobacco                |
| <input type="radio"/> Unpleasant taste or bad breath | <input type="radio"/> Headache                    |
| <input type="radio"/> Sensitivity to hot/cold/sweets | <input type="radio"/> Orthodontic treatment       |
| <input type="radio"/> Other: _____                   |   |

Date of your last dental visit: \_\_\_\_\_

Have you had x-rays taken in the past two years?: \_\_\_\_\_ If 'yes', please have them sent to our office to prevent you from being charged for new ones.

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**Medical History:** Some illnesses and drugs may have a direct effect on the oral cavity and dental treatment. We provide compressive care and it is necessary to have the following information.

Name of physician \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of last physical: \_\_\_\_\_

Please check all that apply to you

- |   |   |   |   |
|---|---|---|---|
| <input type="radio"/> Allergy- Aspirin    | <input type="radio"/> Allergy- Codeine  | <input type="radio"/> Allergy- Erythromycin | <input type="radio"/> Allergy- Latex            |
| <input type="radio"/> Allergy- Penicillin | <input type="radio"/> Allergy- Sulfa    | <input type="radio"/> Allergy-Barbituates   | <input type="radio"/> Allergy- Local Anesthesia |
| <input type="radio"/> Artificial Joints   | <input type="radio"/> Asthma            | <input type="radio"/> Bisphosphonates       | <input type="radio"/> Blood disease             |
| <input type="radio"/> Blood thinners      | <input type="radio"/> Blood transfusion | <input type="radio"/> Cancer                | <input type="radio"/> Chemotherapy              |
| <input type="radio"/> Diabetes            | <input type="radio"/> Drug addiction    | <input type="radio"/> Emphysema             | <input type="radio"/> Epilepsy/Seizures         |
| <input type="radio"/> Excessive bleeding  | <input type="radio"/> Glaucoma          | <input type="radio"/> Head injuries         | <input type="radio"/> Heart valves              |
| <input type="radio"/> Heart Conditions    | <input type="radio"/> Heart Murmur      | <input type="radio"/> High Blood Pressure   | <input type="radio"/> HIV/AIDS                  |
| <input type="radio"/> Kidney Disease      | <input type="radio"/> Liver Disease     | <input type="radio"/> Mental Disorders      | <input type="radio"/> Nervous Disorders         |
| <input type="radio"/> Pacemaker           | <input type="radio"/> Pregnancy         | <input type="radio"/> Radiation Treatment   | <input type="radio"/> Respiratory Problems      |
| <input type="radio"/> Stomach Problems    | <input type="radio"/> Stroke            | <input type="radio"/> Thyroid Disease       | <input type="radio"/> Tuberculosis              |
| <input type="radio"/> Tumors              | <input type="radio"/> Ulcers            | <input type="radio"/> Venereal Disease      | <input type="radio"/> Other _____               |

Are you taking any medications? Please list \_\_\_\_\_

Are you currently under the care of a physician \_\_\_\_\_

For women: Are you pregnant?  Yes  No

Are you nursing?  Yes  No

Are you taking birth control pills?  Yes  No

Please note that antibiotics may reduce the effectiveness of birth control pills

Do you wish to speak privately with the dentist regarding any problem, concern or condition?  Yes  No

## Consent to Services

**I certify that the information I have provided on this form is true and correct in its entirety and have not knowingly omitted any information. Should there be any change in either my health status or any other information I have provided, I will advise this dental office.**

**I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.**

Patient's name (print and sign) \_\_\_\_\_

Legal guardian if patient is a minor (print and sign) \_\_\_\_\_

Dentist's signature \_\_\_\_\_

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