Norwood Dental Centre
344 Marion Street
Winnipeg, Manitoba
R2H 0V3
235-0085

Medical Alert

Patient Information

Date _____

Name _____ _____ ____
First *Last* *Initial*

Date of Birth _____ Age _____ Sex ____ MHSC # _____ PHIN# _____
DD/MMM/YY *M/F*

Address _____
street name and number *city/town* *postal code*

Phone _____ _____ _____ Best way to reach you
home *work* *cell* *home / work / cell*

Employer _____ Email Address _____

Spouse's Information (if applicable)

Name _____ Employer _____ Phone _____ / _____ / _____
home *work* *cell*

Date of Birth _____
DD/MMM/YY

If Patient is a Minor

Mother's Name _____ Employer _____ Phone _____ / _____ / _____
home *work* *cell*

Father's Name _____ Employer _____ Phone _____ / _____ / _____
home *work* *cell*

Insurance Information

Social Insurance # _____ Employee # _____

Are you covered by Dental Insurance? *YES NO* Certificate # _____

Insurance Company _____ Group Policy # _____

Yearly Deductible $ _____ Yearly Maximum $ _____

Does your insurance plan follow the calendar year? *YES NO*

If no, please indicate the coverage dates _____

Are you covered under more than one Dental Plan? *YES NO*

If yes, Name of Company _____ Group Policy # _____ ID # _____

Which plan pays first? _____

Are you covered under any of the following?

Provincial Welfare *YES* *NO* SA # _____

Medical Services *YES* *NO* Treaty Name _____ ID# _____

Medical History

Only questions that have a direct bearing on dental treatment are asked

Name of Physician ______________________________

Date of Last visit ______________________________

Do you have any health problems	YES	NO	
Do you routinely take any medication	YES	NO	
Please list all medications you are currently taking			

____

____

____

____

Have you ever had any of the following:

Tuberculosis or lung disease	YES	NO
Ulcer or stomach problems	YES	NO
Any Unusual Reactions to:		
Penicillin	YES	NO
Aspirin	YES	NO
Codeine	YES	NO
Any Other Drugs/Medication ______________ *specify*		
Allergies to any medication	YES	NO
Allergies to any anesthetics	YES	NO
High or Low Blood Pressure	YES	NO
Heart problems or Stroke	YES	NO
Rheumatic fever or rheumatic heart disease	YES	NO
Prolonged bleeding from a minor cut	YES	NO
Hepatitis or liver trouble	YES	NO
Asthma or sinus problems	YES	NO
Arthritis ro rheumatism	YES	NO
Diabetes or Glaucoma	YES	NO
Kidney or thyroid problems	YES	NO
Nervous problems or epilepsy	YES	NO
Heart murmur	YES	NO
Radiation therapy	YES	NO
Tested positive to HIV virus	YES	NO
Prosthetic Joints	YES	NO
Cancer	YES	NO

Are you pregnant	YES	NO
Have you been treated in the hospital within the last two years	YES	NO

Medical Alert

Info Update

Dental History

Date of last dental examination_____ Last X-ray_____

For Patients with Natural Teeth

Do you have regular check-ups	YES	NO
Are you presently having dental pain	YES	NO
Are you aware of any decayed teeth	YES	NO
Do you have rough or broken fillings	YES	NO
Are your teeth sensitive to heat or cold	YES	NO
sweets	YES	NO
bite pressure	YES	NO
Does food catch between any teeth	YES	NO
Do you have concerns about		
Wisdom Teeth	YES	NO
Bleeding Gums	YES	NO
Bad Breath	YES	NO
Grinding or Clenching your teeth	YES	NO
Jaw Pain	YES	NO
Are you interested in Teeth Whitening	YES	NO
Are you interested in Cosmetic Dentistry	YES	NO

For Patients with Dentures

How long have you worn dentures _____

How old is this set _____

Has your denture been relined	YES	NO
Is your denture comfortable	YES	NO
Do you use denture adhesive	YES	NO
Are you satisfied with the appearance of your dentures	YES	NO
Do your dentures cause sore spots	YES	NO

Attitudes Towards Dentistry

Do you experience anxiety about dental treatment	YES	NO
Has anxiety postponed needed dental treatments	YES	NO
Do you expect to keep your remaining teeth	YES	NO
Would you be interested in having your dental work done under sedation such as Nitrous Oxide	YES	NO
Do you have any concerns regarding any of the following		
X-rays	YES	NO
Fluoride	YES	NO
Dental Amalgam (mercury) fillings	YES	NO

How would you rate the quality of your past dental treatment. Please specify

_____

_____

Medical Alert

Info Update

Please Tell Us

Who may we thank for referring you to our clinic? _____

Financial Policy

A service charge will be applied to accounts with balances over 30 days.

A service charge will be levied on all NSF cheques.

This clinic accepts VISA, MasterCard, Interac or cash.

I acknowledge full responsibility for the payment of all dental services and agree to pay for them in full at the time of service unless other financial arrangements are made.

Signature _____ *Date* _____