Dr. Croppo Dentistry Professional Corp.
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Tel: 905-836-1787 • Fax: 905-836-8249

In order to render the best professional care, it is necessary that we become acquainted with the vital information related to each patient. Of course all information is strictly confidential. We appreciate your cooperation in filling out this form carefully and accurately. (PLEASE PRINT)

			Date
Patient's Last Name	Mr. Mrs. Dr. Ms.	Given Names	Home Phone
Apt. Address		City & Postal Code	Cell
Date of Birth month - day - year -	Driver's Licence	Reason for today's visit ❑ Examination ❑ Emergency	
Occupation	Employer	Business Phone	

In case of emergency notify	Phone	Referred by	Credit Card #
Family Physician	Phone	Previous Dentist	Phone

Primary Insurance Name	Date of Birth	Secondary Insurance Name	Date of Birth
Employer		Employer	
Insurance Company		Insurance Company	
Certificate #	Policy #	Certificate #	Policy #

MEDICAL HISTORY

	Yes	No
★ Is your physician currently treating you for any reason?	❑	❑
If yes, explain _____		
★ Have you ever been hospitalized?	❑	❑
If yes, specify _____		
★ Have you ever had a general anaesthetic?	❑	❑
Any problems? _____		
★ Do you bruise easily or bleed excessively when cut?	❑	❑
★ Are you currently taking any pills, drugs or other medicines?	❑	❑
If yes, please list: 1. _____ 2. _____		
3. _____ 4. _____		
★ Have you ever taken cortisone, steroids, anti-depressants, blood thinners, or thyroid medicine?	❑	❑
★ Do you smoke?	❑	❑
★ Women, are you pregnant? If yes, when do you expect? _____	❑	❑

★ Do you have any or have you ever had any of the following?

- ❑ 1. Heart disease or chest pains
- ❑ 2. High blood pressure
- ❑ 3. Heart murmur
- ❑ 4. Pacemaker or artificial valves
- ❑ 5. Rheumatic fever
- ❑ 6. Diabetes
- ❑ 7. Blood disorders or anemia
- ❑ 8. Lung or breathing problems
- ❑ 9. Asthma
- ❑ 10. Kidney or liver problems
- ❑ 11. Hepatitis
- ❑ 12. Thyroid problems
- ❑ 13. Stomach or intestinal problems
- ❑ 14. Tuberculosis
- ❑ 15. Arthritis
- ❑ 16. Artificial joint replacements
- ❑ 17. Epilepsy or seizures
- ❑ 18. Syphilis, gonorrhoea, AIDS
- ❑ 19. Tumours or cancer
- ❑ 20. Radiation therapy
- ❑ 21. Shortness of breath
- ❑ 22. List all herbal remedies taken _____

Please specify: _____

★ Is there anything else concerning your health the doctor should know?	❑	❑
★ Are you allergic to any medications or drugs?	❑	❑
If yes, explain _____		
★ Do you have any other allergies?	❑	❑
If yes, to what? _____		

Over ☛

DENTAL HISTORY

★ Approximate date of last dental checkup?_____

★ Have you ever had any of the following?

- ❑ 1. Fillings
- ❑ 2. Regular cleanings
- ❑ 3. Recent dental X-rays
- ❑ 4. Nitrous oxide (laughing gas)
- ❑ 5. Periodontics (gum treatment)
- ❑ 6. Caps or crowns
- ❑ 7. Extractions
- ❑ 8. Root canal treatment
- ❑ 9. Full or partial dentures
- ❑ 10. Orthodontics (braces)
- ❑ 11. An injury to your mouth or jaws

	Yes	No
★ Have you ever had a local anaesthetic? If yes, any problems?_____	❑	❑
★ Have you ever had an 'unfavourable' dental experience? If yes, explain_____	❑	❑
★ Would you be interested in having nitrous oxide (laughing gas) during appointments?	❑	❑
★ Do you get 'cold sores' or 'mouth ulcers'? If yes, how often? _____	❑	❑
★ Would you like to improve the general cosmetic appearance of your teeth? What would you like to change? _____	❑	❑
★ Would you like to maintain and keep your natural teeth for a lifetime?	❑	❑

★ Do you presently have or think you may have any of the following?

- ❑ 1. Loose teeth
- ❑ 2. Cavities
- ❑ 3. Gum disease
- ❑ 4. Sensitive teeth
- ❑ 5. Bleeding gums
- ❑ 6. A bad taste in your mouth
- ❑ 7. A clicking or sore jaw
- ❑ 8. Earaches or headaches
- ❑ 9. Unsightly or broken fillings
- ❑ 10. Dead or abscessed teeth

★ In your own words, describe your present dental problem or needs: _____

_____

_____

OFFICE PHILOSOPHY AND POLICY: (Please read)

★ In an effort to determine a treatment plan that is best for your overall dental health, we must make a careful diagnosis. This involves a thorough examination, utilizing the minimum number of X-rays necessary for accuracy.

★ We pledge to provide high quality dentistry in the most comfortable manner possible, with the best equipment, materials and up to date techniques.

★ The longterm success of our efforts will depend on the patients' willingness to maintain their teeth and prevent any future dental problems.

★ **Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require 2 business days notice at which time no charge will be made. Thank you for your consideration.**

★ **Regarding insurance:** This is a contract between you and your employer's insurance company. It is your responsibility to know what your plan covers. However, we are happy to help you with any questions.

★ Any amount not covered by your insurance must be paid in full on the day of your appointment. You will assume responsibility for any fees associated with any treatment performed.

★ A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel relaxed and open to discuss with us, any aspect of your treatment or fees, at any time.

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION CONTAINED IN CLAIMS TO BE SUBMITTED ELECTRONICALLY TO MY INSURANCE COMPANY PLANS ADMINISTRATOR. I ALSO HEREBY AUTHORIZE DIRECT PAYMENT TO DR. CROPPO DENTISTRY PROFESSIONAL CORP. FOR BENEFITS OF ANY CLAIMS SUBMITTED ELECTRONICALLY.

_____ Date

_____ Signature (Parent or Guardian)

★★ We are pleased to welcome you to our practice, and hope to provide you, your friends and relatives with the highest quality of dental care.

Submit