welcome

Please fill out this form completely.
The better we communicate, the better we can care for you.

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DR. VALERIE
STAVRO
LASER + AESTHETIC
DENTISTRY

ABOUT YOU

Name ______________________________

Preferred Name ______________ Gender ______________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate MM/DD/YY Age_____ SIN #___-___-___

Address ______________________________

City ______________ Province ___ Postal Code _______

Email ______________________________

Home # ______________ Work # ______________

Cell # ______________ Fax # ______________

Whom may we thank for referring you? ______________

Other family members seen by us______________

Date of last dental visit ______________

Employer______________ Employer Ph #______________

How long employed there? _________

PARTNER INFO

Name ______________________________

Home # ______________ Work # ______________

Cell # ______________ Birthdate MM/DD/YY

Email ______________________________

ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name ______________ Relation ______________

Home # ______________ Work # ______________

Cell # ______________ Birthdate MM/DD/YY

Email ______________________________

Billing Address ______________________________

City ______________ Province___ Postal Code _______

____

INSURANCE INFO

Provider Name ______________________________

Provider Address ______________________________

City ______________ Prov _____ Postal Code _______

Phone # ______________________________

Group/Plan # ______________________________

ID# ______________________________

Insured's Name ______________________________

Relation ______________________________

Insured's Birthdate ______________________________

Insured'sEmployer ______________________________

Insured'sPh# ______________________________

Insured's SIN# ______________________________

If you have a secondary insurance please let a team member know.

REMINDER INFO

Because we know your life is busy, we use an Electronic Appointment Reminder and Messaging System. Please check all that you prefer, as our best way to contact you.

☐ Email Only ☐ Text Message Only ☐ Text & Email

☐ Personal Phone Call ☐ Don't Need A Reminder

☐ Home ☐ Work ☐ Cell

EMERGENCY CONTACT INFO

In the event of an emergency, who should we contact?

Name ______________ Relation ______________

Home # ______________ Work # ______________

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us.
We are happy to help.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now? ☐ Yes ☐ No

If yes, please explain ______

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, please explain ______

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If yes, please explain ______

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

If yes, please list name and dosage ______

______

Have you ever had joint replacement surgery? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Have you had Botox or facial fillers? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Condition		Condition	
Aids/HIV	Yes No	Hepatitis B,C	Yes No
Alzheimer's	Yes No	Herpes	Yes No
Anaphylaxis	Yes No	High blood pressure	Yes No
Ammonia	Yes No	High cholesterol	Yes No
Angina	Yes No	Hives or rash	Yes No
Arthritis/gout	Yes No	Hypoglycemia	Yes No
Artificial heart valve	Yes No	Irregular heartbeat	Yes No
Artificial joint	Yes No	Joint replacements	Yes No
Asthma	Yes No	Kidney problems	Yes No
Blood disease	Yes No	Leukemia	Yes No
Blood transfusion	Yes No	Liver disease	Yes No
Breathing problem	Yes No	Low blood pressure	Yes No
Bruise easily	Yes No	Lung disease	Yes No
Cancer	Yes No	Mitral valve prolapsed	Yes No
Chemotherapy	Yes No	Osteoporosis	Yes No
Chest pains	Yes No	Pain in jaw joints	Yes No
Cold sores/fever blisters	Yes No	Parathyroid disease	Yes No
Congenital heart disorder	Yes No	Psychiatric care	Yes No
Convulsions	Yes No	Radiation treatment	Yes No
Cortisone medicine	Yes No	Recent weight loss	Yes No
Diabetes	Yes No	Renal dialysis	Yes No
Drug addiction	Yes No	Rheumatic fever	Yes No
Emphysema	Yes No	Rheumatism	Yes No
Epilepsy or seizures	Yes No	Scarlet fever	Yes No
Excessive bleeding	Yes No	Shingles	Yes No
Excessive thirst	Yes No	Sickle cell disease	Yes No
Fainting spells/ dizziness	Yes No	Shortness of breath	Yes No
Frequent cough	Yes No	Sinus trouble	Yes No
Frequent diabetes	Yes No	Spina bifida	Yes No
Frequent headache	Yes No	Stomach/intestinal disease	Yes No
Genital herpes	Yes No	Stroke	Yes No
Glaucoma	Yes No	Swelling of limbs	Yes No
Hay fever	Yes No	Thyroid disease	Yes No
Heart attack/failure	Yes No	Tonsillitis	Yes No
Heart murmur	Yes No	Tuberculosis	Yes No
Heart pacemaker	Yes No	Tumors or growths	Yes No
Heart trouble/disease	Yes No	Ulcers	Yes No
Hemophilia	Yes No	Venereal disease	Yes No
Hepatitis A	Yes No	Yellow jaundice	Yes No

Please list any medical condition(s) that you have ever had:

______

______

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Yes No	Anesthetics	Yes No	Latex	Yes No
Penicillin	Yes No	Acrylic	Yes No	Sulfa drugs	Yes No
Codeine	Yes No	Metal	Yes No		

Please list any other drugs/materials that you are allergic to:

______

FOR WOMEN

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #______

Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

Why have you come to the dentist today? ______

______

______

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? ______

How many times a day do you brush? ______

Type of toothbrush you use: ☐ Manual

☐ Electric ☐ Sonic ☐ Spin

DISCLAIMER

I certify that I have provided an accurate and complete medical and dental history for myself (or my dependant) and have not omitted any information. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

______

Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.