NEW PATIENT FORM

WHO MAY WE THANK FOR REFERRING YOU ?

Bobbie jo Deschamps

SELECT A LOCATION

Kanata

ARE YOU A NEW OR CURRENT PATIENT?

New Patient

PATIENT TYPE

Adult

GENDER

Male

NAME OF PATIENT

Rick Deschamps

DATE OF BIRTH

01/11/1969

ADDRESS

3037 Walker Street

CITY

Cardinal

PROVINCE

Ontario

POSTAL CODE

K0E 1E0

COUNTRY

Canada

EMAIL

Bjdeschamps71@gmail.com

CELL PHONE NUMBER

(613) 340-0905

BEST WAY TO CONTACT YOU:

Cell

FAMILY PHYSICIAN

Dr Peters

EMERGENCY CONTACT

(613) 340-5565

EMERGENCY CONTACT PHONE NUMBER

Bobbie jo

INSURANCE POLICY HOLDER

Self

INSURANCE COMPANY NAME

Canada life

NAME OF INSURANCE POLICY HOLDER

Richard Deschamps

HOLDER DATE OF BIRTH

01/11/1969

INSURANCE POLICY HOLDER

Other

PERSON RESPONSIBLE FOR ACCOUNT

Self

NAME OF GUARDIAN

rick deschamps

PREFERRED METHOD OF PAYMENT

Interact

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS THAT MAY APPLY TO YOU.

- Sensitivity (hot, cold and/or sweet)
- Tooth pain or discomfort while chewing
- Headaches, earaches or neck pain
- Jaw joint pain (clicking/cracking)
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

- None of the above

IF YOU COULD CHANGE YOUR SMILE, YOU WOULD…

- None of the above

HOW IMPORTANT IS YOUR DENTAL HEALTH TO YOU?

6

WHERE WOULD YOU RATE YOUR CURRENT DENTAL HEALTH?

8

WHY ARE YOU LEAVING YOUR PREVIOUS DENTIST?

wife made me

WHAT, IF ANYTHING, IN THE PAST HAS KEPT YOU FROM HAVING DENTAL TREATMENT?

nothing

WHAT IS THE MOST IMPORTANT THING ABOUT YOUR FUTURE SMILE AND DENTAL HEALTH?

keeping my teeth

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITION OR HAVE YOU BEEN TREATED WITHIN THE PAST YEAR?

Yes

PLEASE DESCRIBE:

Diabetes

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?

No

ARE YOU TAKING ANY MEDICATIONS, NON-PRESCRIPTION DRUGS OR HERBAL SUPPLEMENTS OF ANY KIND?

Yes

PLEASE DESCRIBE:

Jardians,

DO YOU HAVE ANY ALLERGIES?

Yes

PLEASE DESCRIBE:

Penicillin

HAVE YOU EVER HAD A PECULIAR OR ADVERSE REACTION TO ANY MEDICINES OR INJECTIONS?

No

DO YOU HAVE OR HAVE YOU EVER HAD ASTHMA?

No

DO YOU HAVE OR HAVE YOU EVER HAD ANY HEART OR BLOOD PRESSURE PROBLEMS?

Yes

DO YOU HAVE OR HAVE YOU EVER HAD A REPLACEMENT OR REPAIR OF A HEART VALVE, AN INFECTION OF THE HEART (I.E. INFECTIVE ENDOCARDITIS), A HEART CONDITION FROM BIRTH (I.E. CONGENITAL HEART DISEASE) OR A HEART TRANSPLANT?

No

DO YOU HAVE A PROSTHETIC OR ARTIFICIAL JOINT?

No

DO YOU HAVE ANY CONDITIONS OR THERAPIES THAT COULD AFFECT YOUR IMMUNE SYSTEM (E.G. LEUKEMIA, AIDS, HIV INFECTION, RADIOTHERAPY, CHEMOTHERAPY)?

No

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESSES OR OPERATIONS?

Yes

PLEASE DESCRIBE:

Bleeding ulcers, pancreatis

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

- diabetes

ARE THERE ANY CONDITIONS OR DISEASES NOT LISTED ABOVE THAT YOU HAVE OR HAVE HAD?

No

DO YOU SMOKE OR USE OTHER NICOTINE PRODUCTS?

No

ARE YOU BREASTFEEDING OR PREGNANT?

No

DO YOU HAVE A DISABILITY OR ARE A PERSON WITH VISUAL IMPAIRMENT

No

I AGREE TO YOUR CANCELLATION POLICY AND UNDERSTAND THAT TWO (2) BUSINESS DAYS NOTICE IS REQUIRED TO RECHEDULE MY APPOINTMENT.

I agree

SIGNATURE

DATE

11/23/2022