



Dentist St. Catharines

THE DENTIST
ST. CATHARINES

PATIENT CONTACT INFORMATION

Mr. Mrs. Ms. Miss Dr. First Name: _____ Last Name: _____
Preferred Name: _____ Date of Birth: _____ (DD/MM/YY) Male Female
Address: _____ Apt/Unit#: _____
City: _____ Province: _____ Postal Code: _____
Home Telephone Number: _____ Email: _____
May we contact you at your workplace? Yes No Work Number: _____ Ext. _____
May we contact you on your cellular phone? Yes No Cell Number: _____
May we contact you by email? Yes No Email Address: _____
Employer: _____ Position: _____
Marital Status: Single Married/Common Law Other
Best way to contact you: Home# Work# Cell# Email
Best time to contact you: Morning Afternoon Evening
In case of an emergency - please notify: _____ Telephone Number: _____

REFERRAL INFORMATION

How did you hear about us? (Check all that apply)

- Internet Web site/search engine source: _____
 Flyer Flyer description: _____
 Newspaper Newspaper name(s): _____
 Phone Book Publisher: Yellow Pages CanPages PhoneGuide GoldBook
 Radio Station(s): _____
 Event Event name: _____
 Word of Mouth Name of person: _____
 Other Please specify: _____
 Mobile Sign
 New Resident Welcome
 Walked By
 Ad Perks/Work Perks

INSURANCE INFORMATION

Primary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
Insurance Policy Holder: Self Parent/Guardian Other _____
Policy Holder Contact Phone Number: _____ (if different from above)
Group Policy/Plan Number: _____ I.D./Certificate Number: _____
Insurance Company Name: _____

Secondary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
Insurance Policy Holder: Self Parent/Guardian Other _____
Policy Holder Contact Phone Number: _____ (if different from above)
Group Policy/Plan Number: _____ I.D./Certificate Number: _____
Insurance Company Name: _____

DENTAL HISTORY

Please check any of the following problems that may apply to you.

- Sensitivity (hot, cold and/or sweet)
- Grinding or clenching teeth
- Tooth pain or discomfort while chewing
- Bleeding, swollen or irritated gums
- Headaches, earaches or neck pain
- Loose, tipped or shifting teeth
- Jaw joint pain (clicking/cracking)
- Bad breath or bad taste in your mouth
- Teeth or fillings breaking

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

- Dentures
- Braces
- Partial dentures
- Periodontal (gum) treatments

Please share the following dates:

Your last dental cleaning: ____ / ____

Your last oral cancer screening: ____ / ____

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes No

Do you smoke or use chewing tobacco? Yes No

If yes, how often? _____ For how long? _____

If you could change your smile, you would...

- Make your teeth brighter
- Make your teeth straighter
- Close spaces
- Replace metal fillings with natural, tooth colored fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 to 10, with 10 being the highest rating

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What, if anything, in the past has kept you from having dental treatment? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your visit today? _____



THE DENTIST
ST. CATHARINES