Patient Information

Dr. Derek Haruta and Associates
101-25 Elm Street, St. Thomas, N5R 1H5
Tel: 519-631-6641 Fax: 519-631-0512
Email: info@drharuta.com

Date: _____

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

☐Dr. ☐Mr. ☐Mrs. ☐Ms. Full Name _____

Age _____ Date of Birth (dd/mm/yyyy) _____ Sex _____

Address _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Employed By _____ Occupation _____

Are you a Post-Secondary Student? ☐Yes ☐No University/College _____

Person Responsible for Account: Name (last/first/middle) _____

Date of Birth (DD/MM/YYYY) _____ Phone _____

Address _____

Employed By _____ Occupation _____

Dental Insurance Type: ☐No insurance ☐Private Insurance ☐C.A.S ☐O.W./ODSP ☐Other

Insurance Company _____ Policy / Plan Number _____

Certificate/I.D # _____

Family Physician _____ City _____ Phone _____

Pharmacy _____ City _____

Previous Dentist _____ City _____

Whom May We Thank For Referring You? _____

In Case Of Emergency Notify (Name) _____

Address _____

Relationship _____ Phone _____

Confidential Medical History

Date of last physical examination _____

Are you presently under the care of a physician? ☐YES ☐NO

Please Specify _____

Are you presently taking any pills, drugs or medication? ☐YES ☐NO

Please Specify _____

Have you taken any prolonged medication in the past? ☐YES ☐NO

Prescription or Non-Prescription? _____

Have you had rheumatic fever? ☐YES ☐NO

Have had heart disease or murmur? ☐YES ☐NO

Do you become breathless easily? ☐YES ☐NO

Have you had abnormal bleeding? ☐YES ☐NO

Have you taken cortisone or steroids? ☐YES ☐NO

Do you have any allergies? ☐YES ☐NO

Do you have allergies to any drugs or medicines? ☐YES ☐NO

i.e. Penicillin. Please specify _____

Have you ever been hospitalized and was surgery performed? ☐YES ☐NO

Please specify _____

Have you ever had or been tested positive for any immunocompromising disease? ☐YES ☐NO

Have you gained or lost excessive weight recently? ☐YES ☐NO

Have you ever had radiation therapy for Cancer treatment? ☐YES ☐NO

Do you have or have you had? Please Check All That Apply.

☐ Anemia
☐ Herpes
☐ Stroke
☐ Scarlet Fever
☐ Arthritis
☐ Low Blood Pressure
☐ High Blood Pressure
☐ Tuberculosis
☐ Nervous Problems
☐ Epilepsy
☐ Psychiatric Care
☐ Ulcer
☐ Thyroid Problems
☐ Diabetes
☐ Venereal Disease
☐ Fainting Spells
☐ Cancer
☐ Liver Trouble
☐ Kidney Trouble
☐ Heart Trouble
☐ Hepatitis
☐ Asthma
☐ Chest Pain
☐ Blood Disorders
☐ Sinus Problems

Are you currently in good health? ☐YES ☐NO

Is there anything else you think you should tell me?

Please specify _____

Are you pregnant? (if applicable) ☐YES ☐NO

Dental History

Are you having any discomfort at this time? ☐YES ☐NO

Please specify _____

Have you ever been given general anaesthetic? ☐YES ☐NO

Please specify _____

Have you been under regular care by a dentist? ☐YES ☐NO

Have you ever been given local anaesthetic (freezing)? ☐YES ☐NO

How long since your last dental visit? _____

Are you aware of any lump or swelling in your mouth? ☐YES ☐NO

What was done at that time? _____

Are you anxious to keep your natural teeth? ☐YES ☐NO

Do your gums feel tender or swollen? ☐YES ☐NO

Are you interested in improving your smile by:

☐Whitening ☐Straightening ☐Replace missing teeth ☐Closing spaces

Describe in your own words what you would like done with your teeth:

_____

Office Policy

Insurance claims can be sent on your behalf to your insurance provider if the company allows it; however, we do not direct bill. Therefore, payments for services are due at the time of each appointment. Your appointment time is especially reserved for you. If you cannot keep the appointment, we require a minimum of 24 hours' notice. If we are not notified, you will be charged for that lost time. Overdue accounts will be subject to interest and collection charges.

Consent for Treatment

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable including the use of local or general anaesthetic as indicated and I will assume responsibility for fees associated with those procedures. I authorize this office to contact my previous dentist, medical doctor(s), Insurance Company, plan administrative at work and share Information as needed. As well as submit insurance claims electronically.

Patient's Signature _____ Date _____