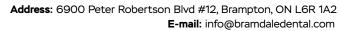


**Ph:** 905-790-2345



## **NEW PATIENT FORM**

at osteoporosis oporsis.)



**Ph:** 905-790-2345



## **NEW PATIENT FORM**

Dental History						
What would you like done	today?					
Do you have a dental pain	(please specify)?					
East as Doublet	Email			Phone		
Former Dentist			FILIDIE			
Address						
Addiess						
Data of last deptal age			Date of last Y-ray			
Date of last dental care	Date of last dental care			Date of last X-ray		
Have you ever had	d any of these conditio	ns (Chack al	that apply)			
•	a arry or these conditio	ilis (Cileck al	і спас арріу)			
☐ Bad breath	☐ Cold sensitivity		growths/sores	☐ Loose teeth/broken filling		
☐ Bleeding gums	Sweet sensitivity		ontal treatment	<ul><li>☐ Clicking/popping jaw</li><li>☐ Food in between teeth</li></ul>		
☐ Hot sensitivity ☐ Biting sensitivity ☐ Gri			ng/clenching teeth	☐ Food in between teeth		
How regularly do you brush	n your teeth? Quantity please?					
How do you feel about you	ur tooth?					
Tiow do you reel about you	i teeti:					
Have you ever had an adve	erse reaction related to a medical/	/dental procedure?	If yes, please describe:			
Other pertinent informatio	n about your dental health:					
		Authori	zation			
t to a second second	the state of the s		le a la contra Contra la con	To do a this information is a constant.		
	-		•	owledge, this information is accurate. I opriate and healthful dental treatments. I		
understand that thi	understand that i ha					
Lauthorize the i	nsurance company to pay t	the dentist all i	nsurance henefits	otherwise payble to me for serviceds		
r additorize dite ii	rendered. I authorize the			·		
I authorize the de	ntist to release all informat	tion necessary	to secure the payr	ment of benefits. I understand that i an		
	financially responsible f					
Signature			Date			