Emergency Treatment

Patient's Name:_____

Parent's / Guardians Name (if applicable): ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____

Home Address: _____

City: _____ **Province**: _____ **Postal Code**:_____ **Email:** _____

Tel: H:(____)_____-_____ W:(_____)_____-_____ ext::_____ Cell: (_____)_____- _____

Birth Date: M:_____D:_____Y:_____ **Age**: _____ **Birthplace**: _____

Driver's Licence or OHIP Number:_____

Pharmacy: Name:_____ Phone #_____Address_____

1. **Do you have any of the following symptoms: fever/feverish, new or existing cough and difficulty breathing? Yes No**
2. **Have you traveled outside Canada within the last 14 days? Yes No**
3. **Have you traveled outside of Ontario in the last 14 days? Yes No**
4. **Have you had close contact with a confirmed or probable COVID-19 case? Yes No**
5. **Have you had close contact with a person with acute respiratory illness who has been outside Canada in the last 14 days? Yes No**
6. Are you an existing patient of Dentistry on Dundas? Yes No
   If no, Name of dentist: _____

Medical History

Family physician:_____ **Telephone**:(____)_____-_____ **Address**: _____

Are you currently under medical treatment?_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (please check if applicable)

☐ Rheumatic Fever	☐ Heart Surgery	☐ Diabetes	☐ Communicable Diseases
☐ Heart Murmur	☐ Thyroid Disorder	☐ Tuberculosis	☐ Osteoporosis
☐ Congenital Heart Lesions	☐ Heart Attack	☐ Kidney Disease	☐ Surgery of any kind
☐ High Blood Pressure	☐ Stroke	☐ Asthma	☐ Hepatitis
☐ Prosthetic Surgery (Heart Valves, Hip Joint)	☐ Pacemaker	☐ Cancer	☐ Pregnancy
☐ HIV Positive/ Aids	☐ Anemia or Blood Problems	☐ Sleep Apnea	Due Date _____

☐ Allergies to Medication: (please check if applicable)

☐ Penicillin ☐ Sulpha ☐ ASA List Medications:_____

☐ Codeine ☐ Erythromycin ☐ Other:_____

Do you smoke ❑ Yes ❑ No

Is there any other information about your health that we should know? _____

Please list any medications you are currently taking:_____

I hereby consent to all dental and oral surgery procedures performed in this office including the use of nitrous oxide, x-rays and /or relevant anaesthesia as indicated and I accept responsibility for all fees charged for treatment rendered whether covered by insurance or not. In addition, I understand that a fee will be charged for missed appointments by myself where at least **48 hours notice** is not provided. I also give consent to photos being taken and used for treatment planning and patient education. I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. I also consent to your collection, of any and all personal information about me including personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course of, concerning, or relating to, your dental treatment. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or part of any treatment or service you provide.

Patient's Signature:_____**Date**_____

Insurance Information

Do you have dental insurance? ☐Yes ☐No **Name of Insured**:_____**Birth Date**:M:___D:____Y:_____

Employer: _____

Insurance Company Name:_____

Policy, Group or Contract #:_____ Member **I.D. or Certificate number**: _____

Credit Card Number:_____ **Expiry date:**_____/____

Name on Card:_____

Sign:_____

Emergency Treatment

Chief Complaint:_____
_____
Area of mouth
:_____
When did it start?
Pain Severity (Please circle): least 1 2 3 4 5 6 7 8 9 10 worst
Is it (please check) Staying the same? Getting Worse? Getting Better?
Medications you have tried or been prescribed to manage this issue:_____
_____
How long have you been taking each medication?: _____
Circle what best describes the pain:
throbbing constant sharp dull Other:_____
Have you communicated by text or email with us regarding this problem? Yes No
With whom did you speak? _____ Did you send any photos? _____

Office use

Findings:_____
_____
_____
_____
_____
____
Diagnosis:_____
_____
__Treatment:_____
_____
_____
_____
_____Follow up Treatment:
_____
_____
_____
__
Prescriptions:_____
_____
__

Treating Dentist

Name : _____ **Sign :**_____ **Date :**_____