



Dr. Neil J. Gajjar, BSc, DDS
Implant, Cosmetic & Family Dentistry

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PERSONAL INFORMATION

Surname _____ First _____ Date of Birth _____ Gender: M F

Address _____ City _____ Postal Code _____

Occupation _____ Employer _____ Address _____

Phone (Res) _____ Phone (Bus) _____ Email _____

Family Physician _____ Phone (Bus) _____ Date of Last Exam _____

Name of Spouse, Parent, or Guardian _____ Marital Status: _____

Occupation _____ Employer _____ Address _____

Phone (Res) _____ Phone (Bus) _____ Emergency _____

Whom may we thank for referring you to our practice?

Magazine Directory Television Newspaper Yellow Pages Radio Peel Region Online _____

Another Patient _____ Doctor _____

Hygienist _____ Staff _____

INSURANCE INFORMATION

Do you have dental insurance? Yes No

Name of insured _____ Insured Date of Birth _____

Insurance Company _____ Group # _____ ID # _____

Driver's License # _____ Credit Card: _____ # _____

This information is collected to verify identity and settle any account balances not covered by insurance.

SECONDARY INSURANCE INFORMATION

Do you also fall into another family members dental insurance? Yes No

Name of insured _____ Insured Date of Birth _____

Insurance Company _____ Group # _____ ID # _____

Driver's License # _____ Credit Card: _____ # _____

This information is collected to verify identity and settle any account balances not covered by insurance.

HEALTH INFORMATION

Have you ever had any of the following? please check those that apply:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | Due _____ | Other: |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Complications |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur F/O | <input type="checkbox"/> Respiratory Problems | after dental treatment |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Need for admission |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | to a Hospital/Emergency |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Under the care |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | of a physician |
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Any health concerns |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors | _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Lukemia | <input type="checkbox"/> Thyroid Problem | _____ |
| <input type="checkbox"/> Fainting Seizures | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | _____ |

DENTAL INFORMATION

Have you ever had any of the following? please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Lip/Cheek Biting | <input type="checkbox"/> Root Canal Therapy |
| <input type="checkbox"/> Bad Experience | <input type="checkbox"/> Extractions | <input type="checkbox"/> Local Anaesthetic Reaction | <input type="checkbox"/> Strong Gag Reflex |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Fillings | <input type="checkbox"/> Loose/Broken Teeth | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Blisters in Mouth | <input type="checkbox"/> Fingernail Biting | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Burning Sensation | <input type="checkbox"/> Food trap in Teeth | <input type="checkbox"/> Mouth Pain | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Chew on one Side | <input type="checkbox"/> Foreign Objects | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Sensitivity to Biting |
| <input type="checkbox"/> Cigarette Smoking | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Pain around Ear | <input type="checkbox"/> Sores/Growths in Mouth |
| <input type="checkbox"/> Clicking Jaw | <input type="checkbox"/> Gums Swollen/Bleeding | <input type="checkbox"/> Peridental Treatment | <input type="checkbox"/> Syncope (Fainting) |
| <input type="checkbox"/> Crowns/Bridges | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Removable Denture | <input type="checkbox"/> Any other conditions |

Reason for today's visit: _____

Former Dentist: _____ City: _____ Prov: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

How often do you brush: _____ Floss: _____

MEDICATIONS

List of medications you are currently taking:

_____ Pharmacy name: _____

_____ City/Prov: _____

_____ Phone: _____

AUTHORIZATION

I have read and answered the questions to the best of my knowledge and understand that I am financially responsible for all charges whether or not paid by insurance.

_____ Signature

_____ Date

DOCTORS NOTES