DR. NEIL J. GAJJAR

ASSOCIATES & SPECIALISTS

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 (DD/MM/YYYY) ______ Gender: M❑ F❑

Address ______________ City ______________ Postal Code ______________

Occupation ______________ Employer ______________ Address ______________

Phone (Res) ______________ Phone (Bus) ______________ Phone (Cell) ______________

Email ______________

Family Physician ______________ Phone (Bus) ______________

Date of Last Exam (DD/MM/YYYY) ______ Marital Status: ______________ Health Card # ______________

Name of Spouse, Parent, or Guardian ______________

Occupation ______________ Employer ______________ Address ______________

Phone (Res) ______________ Phone (Bus) ______________

Emergency Contact ______________ Relationship ______________ Phone ______________

Whom may we thank for referring you to our practice?

❑ Another Patient ______________ ❑ Doctor ______________

❑ Staff ______________ ❑ Online/Social ______________

❑ Advertisement ❑ Magazine ❑ TV ❑ Newspaper ❑ Radio ❑ Other ______________

Insurance Information

Do you have dental insurance? Yes ❑ No ❑

Name of Insured ______________ Insured Date of Birth (DD/MM/YYYY) ______

Insurance Company ______________ Group # ______________ ID # ______________

Driver's License # ______________

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

Secondary Insurance Information

Do you have dental insurance? Yes ❑ No ❑

Name of Insured ______________ Insured Date of Birth (DD/MM/YYYY) ______

Insurance Company ______________ Group # ______________ ID # ______________

Driver's License # ______________

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

See other side.

Health Information

Do any of the following apply to you?

- ❑ AIDS/HIV
- ❑ Allergies
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Cannabis Use
- ❑ Cigarette Smoking
- ❑ Codeine/Penicillin Allergy
- ❑ Diabetes
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy/Convulsions
- ❑ Excessive Bleeding
- ❑ Fainting Seizures
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Attack
- ❑ Heart Murmur F/O
- ❑ Heart Problems
- ❑ Hepatitis: A B C (circle one)
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorder
- ❑ Pacemaker
- ❑ Pregnancy
  Due ____________
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Surgery ______________
- ❑ Thyroid Problem
- ❑ Tumours
- ❑ Ulcers
- ❑ Venereal Disease

Other:

- ❑ Complications after dental treatment
- ❑ Need for admission to a Hospital/Emergency
- ❑ Under the care of a physician
- ❑ Any health concerns

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Dental Information

Please check those that apply:

- ❑ Bad Breath
- ❑ Bad Experience
- ❑ Bleeding Gums
- ❑ Blisters in Mouth
- ❑ Burning Sensation
- ❑ Chewing on One Side
- ❑ Clicking Jaw
- ❑ Crowns/Bridges
- ❑ Dry Mouth
- ❑ Extractions
- ❑ Fillings
- ❑ Fingernail Biting
- ❑ Food Trapped in Teeth
- ❑ Foreign Objects
- ❑ Grinding Teeth
- ❑ Gums Swollen/Bleeding
- ❑ Jaw Pain
- ❑ Lip/Cheek Biting
- ❑ Local Anaesthetic Reaction
- ❑ Loose/Broken Teeth
- ❑ Mouth Breathing
- ❑ Mouth Pain
- ❑ Orthodontic Treatment
- ❑ Pain Around Ear
- ❑ Peridontal Treatment
- ❑ Removable Denture
- ❑ Root Canal Therapy
- ❑ Strong Gag Reflex
- ❑ Sensitivity to Biting
- ❑ Sensitivity to Cold
- ❑ Sensitivity to Hot
- ❑ Sensitivity to Sweets
- ❑ Sores/Growths in Mouth
- ❑ Syncope (Fainting)
- ❑ Any other conditions

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Reason for todays visit: ____

Former Dentist: ______________________ City: ______________________ Prov: __________

Date of last dental visit: ____________________ Date of last dental x-rays: ______________________

How often do you brush: ____________________ Floss: ______________________________

Medication

List of medications you are currently taking:

______________________ ______________________ Pharmacy name: ______________________

______________________ ______________________ City/Prov: ______________________

______________________ ______________________ Phone: ______________________

Authorization

I, the undersigned patient, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information.

I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated.

Unless other arrangements are made, payment is due at each office visit. My dental insurance is a contract between myself and the insurance company, not between my insurance company and the dentist.

I will assume full responsibility for the fees associated with these procedures.

I am aware that 2-business days notice is required to change or cancel an appointment without charge.

I agree that Dr. Neil J. Gajjar & Associates can collect, use and disclose personal information about myself or my dependents as set out in the office's privacy policies, and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. I further agree to receive electronic messages, including text messages, in regards to communicating appointments, requests, information, products, promotions, company news and updates which can be withdrawn at any time. I further consent to being videotaped in public areas of the dental office.

______________________ ______________________ ______________________

Patient/Guardian Signature | Dentist Signature | Date