



# NEXT DIMENSION DENTISTRY

DR. BRENT FAIRBANKS / DR. TROY MICHELSON

## Patient Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ (day/month/year)

Address \_\_\_\_\_ City \_\_\_\_\_

Postal Code \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_

## Medical/Dental History

Date of last dental visit \_\_\_\_\_ Date of last x-rays taken \_\_\_\_\_

Name of previous dentist \_\_\_\_\_ Any current x-rays? \_\_\_\_\_

Have you ever had any reactions to dental freezing? Yes \_\_\_ No \_\_\_

If Yes: \_\_\_\_\_

Are you nervous about seeing a dentist today? Yes \_\_\_ No \_\_\_

Name of medical doctor \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

Do you require any PREMEDICATION before your dental appointments? (Penicillin)  
(i.e. Heart attack, heart murmur, joint replacements, rheumatic fever) Yes \_\_\_ No \_\_\_

If Yes: \_\_\_\_\_

If female, are you pregnant? Yes \_\_\_ No \_\_\_ Possibly \_\_\_

Please check if you have ever been treated for:

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> Heart Trouble or Stroke      | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Cancer   |
| <input type="checkbox"/> Tuberculosis or Lung Disease | <input type="checkbox"/> Blood Disorder      | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Arthritis or Rheumatism      | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Asthma   |
| <input type="checkbox"/> Mental or Nervous Disease    | <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stomach or Intestinal Ulcer  | <input type="checkbox"/> Growth or Tumor     | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hepatitis or Liver Disease   | <input type="checkbox"/> Injury to Face      | <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> High Blood Pressure |                                   |

Prescribed Medications: \_\_\_\_\_

Is there anything that the dentist should know regarding your medical status or health that has not been mentioned? \_\_\_\_\_

Who may we thank for this referral? \_\_\_\_\_

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedure agreed necessary or advisable, including local anaesthetic, sedation as indicated, and I will assume responsibility for all fees associated with these procedures.

PATIENT/PARENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

# Insurance Information

## PRIMARY CARRIER

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ (day/month/year)

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ S.I.N. # \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Div./Branch/Account # \_\_\_\_\_

ID/Coverage # \_\_\_\_\_

Additional Information \_\_\_\_\_

## SECONDARY CARRIER

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ (day/month/year)

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ S.I.N. # \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Div./Branch/Account # \_\_\_\_\_

ID/Coverage # \_\_\_\_\_

Additional Information \_\_\_\_\_