Dr. Janet McGinnis
271 Main Street
Doaktown, NB
(506) 365-4441

Date: _____

Answers to the following questions are important to assessing and recommending changes for your dental health and will be kept confidential.

Miss/Ms./Mrs./Mr._____Date of Birth_____

Address_____City/Town_____

Postal Code_____ Home Phone_____ Cell Phone_____

Work Phone_____ Email_____

CONFIRMING APPOINTMENTS

WE CUSTOMIZE YOUR PREFERRED METHOD TO CONFIRM APPOINTMENTS. ***IT IS VERY IMORTANT YOU CONFIRM APPOINTMENTS PLEASE CHECK YOUR PREFERRED METHOD TO CONFIRM APPOINTMENTS THROUGH OUR AUTOMATED SYSTEM. IT IS IMPORTANT TO KNOW IF YOU DO NOT CONFIRM APPOINTMENTS OUR SYSTEM WILL CONTINUE TO TRY AND CONFIRM. THE WAY TO AVOID THIS IS BY CONFIRMING BY YOUR PREFERRED METHOD WHEN YOU RECEIVE A MESSAGE TO DO SO.***

PREFERRED METHOD TO CONFIR*M email_____ cell (via text message) ____ home phone _____*

FOR PATIENTS WITH DENTAL INSURANCE

Often times Dental Insurance companies pay less of a percentage of the actual fee for service. Therefore the patient of Guarantor is the responsible party for all dental services provided. Ultimately you should be aware of your dental insurance coverage as you are responsible for the fees of the dental services provided. We will do our very best to help you with this !

Occupation: _____Employer: _____

Dental Insurance Company: _____

Additional Information

How long since your last dental checkup? _____

Name of previous dentist: _____

Medical Doctor's Name: _____

PLEASE NOTE: 24 HOUR NOTICE IS REQUIRED FOR ANY CANCELLATION!

Please circle YES or NO to the following questions:

MEDICAL HISTORY

1. Do you have ANY known allergies? If so, please list:
   ALLERGIES_____
   _____
2. Are you currently taking ANY medications? If so, please list:
   MEDICATIONS:_____

   _____

1. Are you worried about receiving dental treatment? YES/NO
2. Have you ever had an injury to you face or jaws? YES/NO
3. Are you being treated for any condition by a physician now? YES/NO
4. Has there been any changes in your general health in the last year? YES/NO
5. Have you ever had any of the following conditions or diseases? (Only circle the disease or condition if the answer is yes)

(a) Asthma	(f) Stroke	(k) Arthritis
(b) Hepatitis- A B C	(g) High or low Blood Pressure	(l) Rheumatic Fever
(c) Tuberculosis	(h) Cholesterol	(m) Cancer/chemotherapy
(d) Artificial heart valve	(i) Epilepsy	(n) Joint Surgery
(e) Heart Disease	(j) Diabetes	(o)Depression/emotional stress

(p) Thyroid (q) Gastrix Reflux (r) Liver disease (s) Kidney Disease (t) Alcohol /Drug issue

(u) Taking Blood Thinner

PLEASE LIST ANY OHTR MEDICAL CONDITION YOU ARE AWARE OF THAT MAY NOT BE LISTED ABOVE

_____

6. Do you bleed for a long time when you cut yourself? YES/NO
7. Do you smoke? YES/NO
8. Do you have frequent severe headaches? YES/NO

17. Are you or is there a possibility of pregnancy at the present time? YES/NO

GENERAL RELEASE: I certify that the information provided is accurate and that I have not knowingly omitted any information. I authorize the dentist to perform diagnostic and restorative procedures as they may be required. I also assume the responsibility for payment of fees associated with the dental care provided.

Signature:_____