Welcome to Balsam Dental!

PATIENT INFORMATION

Mr.☐ Mrs. ☐Ms.☐ Miss☐ First name: ________________________ Last name: __________________

Preferred Name: _________________ Date of birth: ____________ (DD/MM/YYYY) Gender: _______

Address: ____ Apt: _____________________________

City: ______________________ Province:____________________ Postal code: ____________________

Email address: ____

Work number: _______________________ ext: _________________

Cell number: __________________________ Employer: ________________________________

In case of emergency please notify: ________________________ Phone number: _________________

How did you hear about us?

- ☐ Student network
- ☐ Social Media/Email
- ☐ Magazine
- ☐ Building sign
- ☐ Flyer
- ☐ Newspaper
- ☐ Building sign
- ☐ Internet
- ☐ Mobile sign
- ☐ Community event:______________
- ☐ Patient, name: ________________
- ☐ Flyer
- ☐ Other, please specify: ___________

Insurance information:

Primary insurance company information

Name of insurance policy holder: ________________________ Date of Birth: _________(DD/MM/YYYY)
Policy holder contact phone number (if different than above): _________________________________
Group policy/plan number: ____________________ I.D/certificate number: ______________________
Marital status: ☐ Single ☐ Married ☐ Common Law ☐ Other
Insurance company name: ____

Secondary insurance company information

Name of insurance policy holder: ________________________ Date of Birth: _________(DD/MM/YYYY)
Policy holder contact phone number (if different than above): _________________________________
Group policy/plan number: ____________________ I.D/certificate number: ______________________
Marital status: ☐ Single ☐ Married ☐ Common Law ☐ Other
Insurance company name: ____

DENTAL HISTORY

Date of most recent cleaning: ____

Date of most recent dental visit other than a cleaning: ____

I routinely see my dentist every: 3 MONTHS 6 MONTHS 12 MONTHS NOT ROUTINELY

What is the most important thing to you about your dental health: ______________________________

What is the most important thing to you about your visit today? _________________________________

Is there anything about the appurtenance of your teeth that you would like to change? YES ☐ NO ☐

Have you even whitened your teeth? YES ☐ NO ☐

Are you self-conscious about your teeth? YES ☐ NO ☐

Do your gums bleed when brushing/flossing/eating YES ☐ NO ☐

Have you ever been diagnosed or treated for periodontal (gum) disease YES ☐ NO ☐

Responsible party name: ____________________________ Signature: _____________________ Date: ____________