Requested Office(s):

Parkview Oral & Maxillofacial Surgery (Brampton) ☐
Parkview Oral & Maxillofacial Surgery (Ancaster) ☐
Clearview Endodontics (Brampton Only) ☐

Initial Patient Form

OHIP#(Health Card): _____

(Required for prescription purposes only - OHIP does not cover dental office fees)

Reason for Visit: _____

Name: Mr./ Miss/ Mrs./ Dr. _____

(Please circle which one) FIRST LAST

Age: _____ Gender: M F

MM DD YYYY

Address: _____ Unit/Apt: _____

City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Referring Dentist: _____

Family Physician: _____ Family Dentist: _____

In case of Emergency please notify: Name: _____ Phone: _____

Relation: _____

Do you have dental insurance: ☐ No ☐ Yes

We collect insurance information to help prepare claims and estimates on your behalf. Providing this information is optional—you are not required to share it. This includes private plans and government-funded programs such as CDCP, NIHB, ODSP, HSO, OW, etc. If you are covered under a government program, please contact our office directly to determine if our office accepts the coverage. We can provide you details on what's covered, how payments work, and whether any balance may remain.

Primary Dental Insurance:

Insurance Company / Employer _____

Name of Policy Holder _____

Date of Birth (MM/DD/YYYY) _____

Relation to Patient _____

Group/Plan/Policy/Contract Number _____

Patient ID/Member Certificate Number _____

Secondary Dental Insurance:

Insurance Company / Employer _____

Name of Policy Holder _____

Date of Birth (MM/DD/YYYY) _____

Relation to Patient _____

Group/Plan/Policy/Contract Number _____

Patient ID/Member Certificate Number _____

IMPORTANT: On day of surgery with General Anaesthetic or Intravenous Sedation, you must be accompanied by an adult and they must remain in the office for the COMPLETE VISIT.

FEES: OHIP does not cover office procedures: DENTAL INSURANCE MAY NOT COVER THE TOTAL FEE. Full payment is required the day services are rendered. Please note that the financial obligation is between you and this office.

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The surgeon will review the questions and explain anything that you do not understand. Please fill in the entire form.

Would you consider yourself in good health? ☐ Yes ☐ No

Are you under the care of a physician for any medical condition within the last 2 yrs? If yes, please explain: ☐ Yes ☐ No

Are you Pregnant/Nursing? (if applicable): ☐ Yes ☐ No

Have you ever been hospitalized? If yes, please explain: ☐ Yes ☐ No

Have you recently, or are you presently, taking any medications, nonprescription drugs or herbal supplements of any kind? If yes, please list them below (if you have a medication list, please provide it to the front staff with your forms): ☐ Yes ☐ No

1. 2. 3.

4. 5. 6.

7. 8. 9.

Are you allergic to any medications, foods or latex/rubber products? If yes, please list: ☐ Yes ☐ No

Have you ever had an adverse reaction to any medications or injections? If yes, please explain: ☐ Yes ☐ No

Do you have a prosthesis or artificial joint of any kind? If yes, please explain: ☐ Yes ☐ No

Are you HIV Positive or Hepatitis C Positive? If yes, please explain: ☐ Yes ☐ No

Have you ever had surgery? If yes, please list/explain: ☐ Yes ☐ No

Do you smoke or use other forms of tobacco, marijuana or use other recreational drugs? If yes, please list: ☐ Yes ☐ No

HAVE YOU HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING? (Note: If there is an option, please circle the one that applies to you)

Artificial Heart Valve	☐Yes ☐No	Asthma	☐Yes ☐No	Anemia	☐Yes ☐No
Atrial Fibrillation	☐Yes ☐No	Bronchitis/Pneumonia	☐Yes ☐No	Bleeding Disorder	☐Yes ☐No
Chest Pain	☐Yes ☐No	Difficulty Breathing	☐Yes ☐No	Blood Thinner Use	☐Yes ☐No
Circulation Problems	☐Yes ☐No	Lung Disease (Emphysema/COPD)	☐Yes ☐No	Hepatitis A, B or C	☐Yes ☐No
Congenital Heart Disease	☐Yes ☐No	Rheumatic/Scarlet Fever	☐Yes ☐No	Liver Disease/Jaundice	☐Yes ☐No
Heart Attack or Disease	☐Yes ☐No	Sleep Apnea (If yes, CPAP use? Y/N)	☐Yes ☐No	Peptic Ulcers	☐Yes ☐No
Pacemaker or Defribrillator	☐Yes ☐No	Sinus Problems/Sinusitis	☐Yes ☐No	Sickle Cell Anemia	☐Yes ☐No
Heart Rhythm Disorder	☐Yes ☐No	Tonsillitis	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No
Heart Surgery	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Drug/Alcohol Addiction	☐Yes ☐No
High or Low Blood Pressure	☐Yes ☐No	Arthritis	☐Yes ☐No	Head and/or Neck Injury	☐Yes ☐No
Mitral Valve Prolapse	☐Yes ☐No	Autoimmune Disorder	☐Yes ☐No	Malignant Hyperthermia	☐Yes ☐No
Stroke	☐Yes ☐No	Diabetes (If yes, Insulin use? Y/N)	☐Yes ☐No	Psychiatric Treatment	☐Yes ☐No
Cancer	☐Yes ☐No	Glandular Disorders	☐Yes ☐No	Autism/Cognitive Disorder	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Glaucoma	☐Yes ☐No	Developmental Disorder	☐Yes ☐No
Radiation to Head/Neck/Jaw	☐Yes ☐No	Herpes	☐Yes ☐No	Sexually Transmitted Disease	☐Yes ☐No
Steroid Use (Prednisone/Cortisone)	☐Yes ☐No	Organ Transplant	☐Yes ☐No	TMJ Problems	☐Yes ☐No
Kidney Disease/Dialysis	☐Yes ☐No	Thyroid Disease	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Crohn's Disease/Ulcerative Colitis/Intestinal Problems	☐Yes ☐No	THC/Cannabis/Marijuana Use (Important to know in order to administer safe level of sedation)	☐Yes ☐No	Bone Medication Use (e.g. Actonel/Prolia) (If yes, for how many years?____)	☐Yes ☐No

Do you have any other medical conditions not listed above? If yes, please explain: ☐ Yes ☐ No

To the best of my knowledge, the information that I have provided is correct and accurate.

Patient/Guarantor Signature:_____ Name: _____ Date: _____