New Patient Information

MOONLIGHT DENTISTRY

Patient Information

First Name: _____

Last Name: _____

Preferred Name: _____

Date of Birth (DD/MM/YYYY)**:** _____

OHIP (Optional)**:** _____

Address: _____

City: _____ **Postal Code**: _____

Home Phone: _____

Mobile Phone: _____

Email: _____

Preferred Method of Contact

☐ Phone ☐ Text ☐ Email

Emergency Contact

Name: _____
Relationship: _____
Phone Number: _____

Family Physician

Physician's Name: _____
Phone Number: _____

Dental Insurance

Primary Insurance Company: _____

Policy Holder: _____

Relationship to Patient: _____

Policy/Group Number:
_____

Certificate/ID Number:
_____

Medical History

Are you currently under the care of a physician?

☐ Yes ☐ No

If yes, explain: _____

New Patient Information

MOONLIGHT DENTISTRY

Please check any conditions that apply:

☐ Heart Disease
☐ High Blood Pressure
☐ Diabetes
☐ Stroke
☐ Asthma
☐ COPD
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disease
☐ Osteoporosis
☐ Arthritis
☐ Cancer
☐ Seizures
☐ Sleep Apnea
☐ Bleeding Disorder
☐ Hepatitis
☐ HIV/AIDS
☐ Joint Replacement
☐ Artificial Heart Valve
☐ Other:

Allergies

☐ None
☐ Medications
☐ Latex
☐ Foods
☐ Other
Details:

Medications

Please list all current prescription, over-the-counter medications.

For Female Patients

☐ Pregnant ☐ Nursing ☐ Planning Pregnancy ☐ Not Applicable

Dental History

Reason for today's visit: _____ Previous Dentist: _____
Date of last dental visit: _____ Date of last dental X-rays: _____

Have you ever had any of the following?

☐ Dental Anxiety
☐ Difficulty Freezing
☐ Jaw Pain (TMJ)
☐ Grinding/Clenching
☐ Sensitivity
☐ Bleeding Gums
☐ Gum Disease
☐ Dry Mouth
☐ Complications after dental treatment
☐ None

New Patient Information

Comments:

Social History

Do you smoke or vape?

☐ Never ☐ Former ☐ Current

Alcohol Use:

☐ None ☐ Occasional ☐ Regular

Recreational Drug Use:

☐ No ☐ Yes

Privacy & Consent

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform the dental office of any changes to my medical history, medications, or contact information.

I authorize the dental team to collect, use, and disclose my personal health information for the purpose of providing dental care, communicating with other healthcare providers when necessary, processing insurance claims (where applicable), and as otherwise permitted or required by law.

I understand that I am responsible for fees not covered by my insurance.

Patient/Guardian Name: _____

Signature: _____

Date: _____

Reviewed by: _____