

Bal Dental Centre

Dr. Gus Bal D.M.D.

PERSONAL INFORMATION (please print)

Patient Name _____
(Last) (First) (Mr/Mrs/Miss/Ms/Dr)

Address _____
Street name & # Apt # City Postal Code

Telephone: (H) _____ Birth Date: _____
DD/MM/YYYY

(B) _____ ext _____ Email _____

(C) _____ Spouse's Name: _____ D.O.B. _____
D/M/Y

WHOM MAY WE THANK FOR REFERRING YOU _____

In case of emergency,
contact _____ Tel: _____ Relationship _____

****Please Note****

For your convenience we will bill your insurance company directly, however your plan is subject to change without notice therefore we cannot be held responsible for any treatment not covered.

Primary Coverage

Secondary Insurance

Employee Name: _____

Employee Name: _____

Company Name: _____

Company Name: _____

Insurance Company: _____

Insurance Company: _____

Group or Policy# _____

Group or Policy# _____

Certificate # _____

Certificate # _____

Medical History Form

Please check if you now have or have had any of the following

- | | | |
|--|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Hay fever/allergies |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung Trouble | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Prosthetic Valve | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Low Blood pressure | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> HIV (or related) | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nervous Disorder |

MEDICAL

WHAT IS THE DATE OF YOUR LAST PHYSICAL EXAMINATION: _____

NAME OF YOUR FAMILY DOCTOR: _____

Do you smoke? **How much?** _____

Are you currently taking any Prescription medications? Please List _____

Are you **ALLERGIC** or sensitive to medication or **LATEX**? _____

Do you use aspirin or blood thinners? _____

For women: Are you pregnant? _____

Are you under the care of a physician? For what? _____

DENTAL

NAME OF PREVIOUS DENTIST: _____

DATE OF YOUR LAST DENTAL APPOINTMENT: _____

DATE OF YOUR LAST DENTAL X-RAYS: _____

- Yes No Do your gums bleed with brushing or flossing?
- Yes No Do you hear popping, clicking noises or have pain when you chew?
- Yes No Have you ever experienced problems during dental treatment?
- Yes No Do you have any concerns regarding the appearance of your teeth?

Is there anything missed on this form you feel we should know? _____

I hereby authorize Dr. Bal to perform necessary treatment including emergency treatment, recall maintenance, periodontics, endodontics, oral surgery, fixed/removable prosthodontics. I consent to the administration of local anesthesia as well as any pertinent radiographs necessary. I have had explained to me, by Dr. Bal, the purpose and benefits of the procedures recommended for my dental treatment. I certify that no guarantee has been made or assurance given to the results that may be obtained.

Patients Signature _____ Date _____

Reviewed by: _____ Date _____