7322 Highway 1
Coldbrook, NS B4R 1B9

Dr. Scott Schofield, BScH, DDS
Dr. Elizabeth Jackson, BScH, DDS
Dr. April Nason, BSc, DDS

PERSONAL INFORMATION

Birth date: ________________________ Health Card No.______________

Name: ___________________________ Address: ____

Town: _____________Prov: ________ Postal Code: _______________ email: ____________________

Occupation: ______________________________Employer: _____________________________________

Home Phone:_____________________________Work Phone:_____________________________________

Parent / Guardian (if under 18) or Next of Kin:_____________________________Phone:_______________

Family Doctor:_____________________ Town:____

Do you qualify for government assistance with dental care? Yes / No Social Assistance, NIHB, Veteran's Affairs

Do you have Private Dental Insurance? Yes / No Can we send claims electronically for you? Yes / No

Please provide details of your insurance plan to our receptionist, and if there is secondary coverage through a spouse

DENTAL HISTORY

What brings you to this office today? ____

Emergency Specific exam Consult for sedation / Implants

Do you have a regular dentist? Yes / No Name: _________________ Town: ____________________

Can Fundy Dental Centre send clinical notes and x-rays from this visit to your dentist? Yes / No

Do you seek regular preventative dental care? Yes / No Last Dental Visit Date: _______________

Have you had issues with dental treatment in the past? please explain ______________________________

Do visits to the dentist make you nervous? (circle one) Not at all / Somewhat / Moderate / Very / Extremely

How did you hear about this office? Location / Website / Yellow Pages / Facebook / Twitter / Radio Ads

Please circle one option Friend / Dentist / Doctor / Emergency Room / Social Services / Other

MEDICAL HISTORY

Are you in good health? Yes / No

Have you had a physical exam in the past 6 months? Yes / No Do you smoke? Yes/ No How long? _____

Do you drink more than 10 alcoholic beverages per week? Yes / No

Do you have any allergies? Please list: ____

Are you taking any medications? Please list or provide a copy: _____________________________________

____

____

Are there medical conditions that you are being treated for at this time? __________________________

____

Do you have a history of, or present issue with, any of the following? Abnormal Heart Condition □ Diabetes □
Heart Attack □ Prolonged Bleeding or Disorder □ Asthma □ Breathing Issue □ Liver/Kidney Disease □ Cancer / Tumor □
High Blood Pressure □ Migraines □ Hive □ Stroke □ Psychiatric Treatment □ Major Injury □ STD/HIV+/AIDS □ Drug Abuse □

Other □ ____

Are any of the above uncontrolled or require further information? _____________________________

To the best of my knowledge, all preceding answers are true and correct. Please inform your dentist of any change in health or medications. Also, please review our **Privacy and Consent Statement** in the waiting area.

Signed: ___________________________________

Date: ___________________________________

Office Only

HR: _________Exam: __________

BP: _________X-ray: __________