7322 Highway 1
Coldbrook, NS B4R 1B9

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

FUNDY DENTAL Re-TREATMENT FORM

Birth date: ________________________ Health Card No.____________________

Name: ___________________________ Street Address: ____

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

Phone: H__________________________ C _______________________ W________________________

INSURANCE INFORMATION

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 if there are changes since your last visit

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

MEDICAL HISTORY

Has there been any change in your health since your last visit? Yes / No
Please explain: ____
____

Are you being treated for, or do you have, any medical conditions? ______________________________
____

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

Do you have any allergies? Please list: ____

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: __________