

Welcome to Our Office

In an effort to serve you better, we ask that you complete the following.
We will be glad to assist you. **PLEASE PRINT**

Patient Information

A parent or guardian will be responsible for decisions on my treatment Yes No

Name: _____
First Initial Last

Address: _____
Street Apt.

_____ *City Prov. Postal Code*

Date of Birth: ___/___/___ Home Tel. (____) _____ Work Tel. (____) _____
D M Y

Emergency Contact: _____ Tel. (____) _____

Family Doctor: _____ Tel. (____) _____

Referring Doctor: _____ Tel. (____) _____

Whom may we thank for referring you? _____

Financial Information

Method of Payment: Cash Cheque Credit Card Insurance Other

Person responsible for financial matters: Self Spouse Parent/Guardian Other

If Different than Above:

Name: _____ <i>First Initial Last</i>
Address: _____ <i>Street Apt.</i>
_____ <i>City Prov. Postal Code</i>
Date of Birth: ___/___/___ Home Tel. (____) _____ Work Tel. (____) _____ D M Y

Insurance

Insurance Company: _____ Tel. (____) _____

Employer/Policy Holder _____ Ins. Yr. End: _____

Policy# _____ Certificate# _____ ID# _____

Max Cov. _____ %coverage for ___ Basic ___ Maj. Restorative ___ Orthodontic

Dental History

- What is the reason for today's visit? Emergency Examination Other
- How frequently do you see a dentist? 3-6 months Annually Other
- When was your last dental visit? _____ Last X-Ray? _____
- How often do you brush per day? _____ Floss? _____ Use Anti-bacterial rinse? _____
- Are your teeth sensitive to: Cold Sweets Heat Other _____
- Do your gums bleed when: Brushing Flossing Never **YES NO**
- Do your gums feel swollen or tender?
- Do you have bad breath or a bad taste in your mouth?
- Do your jaws crack, pop or grate when you open widely?
- Do you grind or clench your teeth?
- Do you have food catch between your teeth?
- Have you ever had local anaesthetic (freezing)?
- Any complications? Yes No Specify _____
- Have you ever had any problem with previous dental treatments?
- Specify _____
- Have you ever had any of the following: Bridgework Crowns or Caps
 Full or Partial Dentures Orthodontic (braces) Peridontal (Gums) Root Canal
- Are you satisfied with your teeth? Specify _____

Medical History (This information will remain confidential) Date: _____ **YES** **NO**

1. Are you presently under the care of a physician? if so, explain. _____
2. Have you ever been hospitalized?.....
 Explain _____
3. Are you taking any drugs or medications at this time?.....
 A) Drug _____ Reason _____
 B) Drug _____ Reason _____
 C) Drug _____ Reason _____
4. Have you ever had any adverse effects to any of the following:
 Antibiotic-Penicillin Sulfonamide Other
 Aspirin Barbiturates (sleeping pills) Codeine
 Darvon Local Anaesthetic NONE
5. Have you ever been warned against using any other medications?.....
 Which? _____
6. Have you ever taken prolonged medical or non-medical drugs?.....
 Which? _____
7. Do you suffer from allergies (hay fever, latex, etc.)?.....
 Which? _____
8. Do you bruise easily or have prolonged bleeding?.....
9. Do you smoke? How much per day?.....
10. Have you ever fainted, had shortness of breath or chest pains?.....
11. WOMEN: Are you pregnant? Yes No If Yes, which trimester? _____
 Using Birth Control Yes No
 Reached menopause? Yes No

12. Do you have or have you ever had any of the following? Please ✓ appropriate boxes. NONE

- | | | |
|--|--|--|
| <input type="checkbox"/> A.I.D.S | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glandular disorders | <input type="checkbox"/> Malignant hyperthermia |
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental/nervous disorder |
| <input type="checkbox"/> Anorexia nervosa | <input type="checkbox"/> Head/Neck injuries | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Arthritis/rheumatism | <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Organ transplant/implant |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Artificial joints (hip, knee) | <input type="checkbox"/> Heart pacemaker/surgery | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart rhythm disorder | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> H.I.V. Positive | <input type="checkbox"/> Stomach/intestinal problems |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Hodgkins disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Hyper (Hypo) Glycemia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cortisone/steroid | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Drug/Alcohol dependence | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other |

13. **CHILDREN** Have you recently had any of the following (approximate date)?
- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Strep Throat _____ | <input type="checkbox"/> Tonsillitis _____ | <input type="checkbox"/> None |

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature Self Parent/Guardian _____ Print name _____ Date _____

Thank you!