

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: _____
First Initial Last

Address: _____
Street Apt.

City Prov. Postal Code

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

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other ☐
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other ☐
3. When was your last dental visit? _____ Last X-Ray? _____
4. How often do you brush per day? _____ Floss? _____ Use Anti-bacterial rinse? _____
5. Are your teeth sensitive to: _____ Cold _____ Sweets _____ Heat _____ Other _____

6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never YES NO
7. Do your gums feel swollen or tender? _____ ☐ ☐
8. Do you have bad breath or a bad taste in your mouth? _____ ☐ ☐
9. Do your jaws ever pop, click or crack when opening or closing your mouth? _____ ☐ ☐
10. Do you grind or clench your teeth? _____ ☐ ☐
11. Do you have food catch between your teeth? _____ ☐ ☐
12. Have you ever had local anaesthetic (freezing)? _____ ☐ ☐
Any complications? Yes No Specify
13. Have you ever had any problem with previous dental treatments? Specify _____ ☐ ☐
14. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps
☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Peridontal (Gums) ☐ Root Canal

15. Are you satisfied with your teeth? Specify _____ ☐ ☐

Medical History (This information will remain confidential) Date: _____

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 | YES | NO |

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

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

13.CHILDREN Have you recently had any of the following (approximate date)?

- | | | |
|---|--|--------------------------------------|
| ☐ Chicken Pox _____ | ☐ Measles _____ | ☐ Mumps _____ |
| ☐ Strep Throat _____ | ☐ Tonsillitis _____ | ☐ 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
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Thank you!