Welcome

In an effort to serve you better we would 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: (_____)_____

Financial information

Method of payment: Cash ☐ Cheque ☐ Credit card ☐ Insurance ☐ Other ☐

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

IF Different From Above

Name: _____
First initial Last

Address: _____
Street Apt City Prov. Postal Code

Date of Birth: _D__/_M___/__Y__ Home Tel: (_____)_____ Work Tel: (_____)_____

Primary Insurance

Ins, 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 fee swollen or tender?.....	☐	☐
8. Do you have bad breath or a bad taste in your mouth?.....	☐	☐
9. Do your jaws crack pop or grate when you open Widely?.....	☐	☐
10. Do you grind or clench your teeth?.....	☐	☐
11. Do you have food catch between your teeth?.....	☐	☐
12. Have you ever had local anesthetic Freezing any complications? ☐ Yes ☐ No Specify_____	☐	☐
13. Have you ever had any problems with previous dental treatments? Specify_____	☐	☐

14. Have you ever had any of the following:

☐ Bridgework ☐ Crowns or Caps ☐ Full or Partial Dentures
☐ Orthodontic (Braces) ☐ Periodontal (Gums) ☐ Root Canal

15. 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 medication at this time..... ☐ ☐

A) Drug _____ Reason_____
B) Drug _____ Reason_____
C) Drug _____ Reason_____

4. Have you ever had any adverse effect to any of the following: Antibiotic- Penicillin☐, Sulfonamide ☐ , Other☐;

Aspirin☐ ; Barbiturates (sleeping pills) ☐ ; Codeine ☐; Darvon☐; Local Anaesthetic ☐ ; NONE ☐

YES NO

5. You ever being warned against using any other medications? Which? _____ ☐ ☐
6. Have you ever taken prolonged medical or non-medical drugs? Which ? _____ _____ ☐ ☐
7. Do you suffer from any 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 pain? _____ ☐ ☐
11. **WOMEN** are you pregnant? Yes☐ No☐ 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	☐ Cortisone/steroid	☐ High/low blood pressure
☐ Anemia	☐ Diabetes	☐ Radiation/Chemotherapy
☐ Angina pectoris	☐ Drug/alcohol dependence	☐ Rheumatic/Scarlet fever
☐ Anorexia nervosa	☐ Emphysema	☐ Sickle Cell disease
☐ Artificial Heart valve	☐ Epilepsy	☐ Sinus trouble
☐ Arthritis/rheumatism	☐ Glandular disorders	☐ Stomach/intestinal problem
☐ Artificial joints (hips, Knees)	☐ Glaucoma	☐ Stroke
☐ Asthma	☐ Head/Neck injuries	☐ Thyroid disease
☐ Blood disorders	☐ Heart disease/attack	☐ Tuberculosis
☐ Bronchitis	☐ Heart murmur	☐ Ulcers
☐ Bulimia	☐ Heart pacemaker/surgery	☐ Venereal disease
☐ Cancer	☐ Heart rhythm disorder	☐ Other
☐ Circulation problems	☐ Hepatitis A/B/C	☐ Other
☐ Congenital heart lesions	☐ Herpes	☐ Other

13. **CHILDREN** happy 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 of 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 the 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 Patient ☐ Parent/Guardian ☐ Print Name Date

Thank You