

PATIENT INFORMATION



PERSONAL INFORMATION

Full Name :

Home Address :

Date of Birth :

 / /

Gender :

Pronouns:

Day-time Phone:

Email :

Occupation:

Business Address:

Work Phone:

EMERGENCY DETAILS

Name:

Name:

Relationship:

Relationship:

Day-time Phone:

Day-time Phone:

Family Doctor:

Specialist:

Phone:

Phone:

Address:

Address:

INSURANCE (DO NOT FILL OUT)

Primary Insurance

Holder:

Insurance Co:

Group #:

Member #:

Phone:

Secondary Insurance

Holder:

Insurance Co:

Group #:

Member #:

Phone:

How did you hear about our office? (Please Circle)

Online Search

Social Media

Reviews

Advertisement

Friend/ Family Member

Other:

MEDICAL HISTORY



Are you currently being treated for any medical conditions or have been treated within the past year?

If Yes please explain: (Please Circle) **Yes** **No** **Not Sure/ Maybe**

When was your last medical check up?:

Have there been any health changes for you in the past year? If Yes. Please explain.

Yes **No** **Not Sure/ Maybe**

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them. **Yes** **No** **Not Sure/ Maybe**

Do you have any allergies? If yes, please list them below: **Yes** **No** **Not Sure/ Maybe**

a) medications

b) latex/rubber products

c) other

Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

Yes **No** **Not Sure/ Maybe**

Do you have or have you ever had asthma? **Yes** **No** **Not Sure/ Maybe**

Do you have or have you ever had any heart or blood pressure problems? **Yes** **No** **Not Sure/ Maybe**

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? **Yes** **No** **Not Sure/ Maybe**

Do you have a prosthetic or artificial joint? **Yes** **No** **Not Sure/ Maybe**

Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? **Yes** **No** **Not Sure/ Maybe**

Have you ever had hepatitis, jaundice or liver disease? **Yes** **No** **Not Sure/ Maybe**

Do you have a bleeding problem or bleeding disorder? **Yes** **No** **Not Sure/ Maybe**

MEDICAL HISTORY



Have you ever been hospitalized for any illnesses or operations? If yes, please explain.

Yes No Not Sure/ Maybe

Do you have or have you ever had any of the following? Please circle

Angina	Heart Murmur	Medications (Fosamax, Actonel)	Thyroid Disease
Arthritis	Heart Attack	Osteoporosis	Transient Ischemic Attack
Cancer	Kidney Disease	Pacemaker	Tuberculosis
Chest Pain	Lung Disease	Rheumatic Fever	Stroke
Diabetes	Mitral Valve Prolapse	Stomach Ulcers	Steroid Therapy
Drug/ Alcohol/ Cannabis Use or Dependency			Seizures (Epilepsy)

Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.

Yes No Not Sure/ Maybe

Are there any diseases or medical problems that run in your **family** (e.g. diabetes, cancer or heart disease)? Yes No Not Sure/ Maybe

Do you smoke or chew tobacco products? Yes No Not Sure/ Maybe

Are you nervous during dental treatment? Yes No Not Sure/ Maybe

Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

Yes No Not Sure/ Maybe

Do you identify as a patient with a disability? If yes, please explain. Yes No Not Sure/ Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature:

Date:

Dentist Signature:

Date:

Dentist Notes

DENTAL HISTORY



DENTAL HEALTH

Do you notice any bleeding in your gums when you brush or floss?	Yes	No	Not Sure/ Maybe
Do hot or cold beverages and foods cause sensitivity in your teeth?	Yes	No	Not Sure/ Maybe
Do you experience tooth sensitivity when consuming sweet or acidic foods/drinks?	Yes	No	Not Sure/ Maybe
Are any of your teeth causing you discomfort or pain?	Yes	No	Not Sure/ Maybe
Are there any ulcers or abnormal growths in your mouth or its surrounding area?	Yes	No	Not Sure/ Maybe
Have you sustained injuries to your head, neck, or jaw area? If yes, please explain.	Yes	No	Not Sure/ Maybe

DENTAL HISTORY

Is teeth clenching or grinding an issue for you?	Yes	No	Not Sure/ Maybe
Have you undergone any dental or oral surgeries, including the removal of wisdom teeth? If yes, please explain	Yes	No	Not Sure/ Maybe
Have you experienced extended bleeding after any dental procedures?	Yes	No	Not Sure/ Maybe
Have any tooth extractions been particularly troublesome for you in the past?	Yes	No	Not Sure/ Maybe
Have you ever received orthodontic care, such as braces?	Yes	No	Not Sure/ Maybe

Dentist Notes