## Welcome to the Practice

The following questionnaire will help us provide you with the highest standard of dental care. Please be assured that all information will remain confidential. We will happily assist you if you have any problems filling out this form.

REGISTRATI	ON INFORMATION
Patient is an/a: ☐ Adult ☐ Child If Child	d – Name of Parent/Guardian:
Name:	
(First Name)	(Middle Initial) (Duefous to be called)
(First Name) (Last Name)	(Middle Initial) (Prefers to be called)  Date of Birth:
☐ Male ☐ Female	
☐ Single ☐ Married ☐ Divorced ☐ Wid	DD/MM/YYYY  dowed □ Separated
Address:	Jowed 🗀 Separated
(6)	
(Street) Work Phone:	(City) (Province) (Postal Code) Other Phone:
Employer:	Occupation:
What is the best phone number to use to contact you?	
E-mail Address:	
Are other family members, patients at our office?	If yes, name:
How did you hear about us?	
, <u> </u>	
If you were referred, whom may we thank for referring you	?
MEDIC	AL CONTACTS
Family physician:	Phone:
In case of emergency, please contact:	Phone:
'	,
FINANCIA	LINFORMATION
Responsibility for account:   Self Spouse O	
Please complete only if information is different from above Address:	): 
Address.	
(Street)	(City) (Province) (Postal Code)
Drimon, Doubel Incomes	Consorder Dontel Income
Primary Dental Insurance Subscriber's Name:	Secondary Dental Insurance Subscriber's Name:
Subscriber's Name.  Subscriber's Date of Birth:	Subscriber's Name.  Subscriber's Date of Birth:
DD/MM/YYYY	DD/MM/YYYY
Insurance Company:	Insurance Company:
Group/Policy #:	Group/Policy #:
I.D.#/Certificate #:	I.D.#/Certificate #:
	INFORMATION
Are you having any pain or specific problems or concerns w Have you or do you have pain or discomfort in the jaw joint	•
Do you drink more than 4 cups/cans of coffee, tea, pop, and	· · · ·
Do you experience discomfort or bleeding with your gums?	
Have you had any problems or difficulties with dental treat	
Do you feel nervous about receiving dental treatment?	☐ Yes ☐ No
Do you require antibiotics before dental treatment?	☐ Yes ☐ No
Do you snore or have you been diagnosed with sleep apnear Do you frequently breathe through your mouth instead of your mouth instead	
	/our nose? ☐ Yes ☐ No

	MEDICAL INFORMATION			
Have you recently been under the care of a physician?			☐ Yes	□ No
Have you had a medical exam within the last year?			☐ Yes	☐ No
Have you been hospitalized or had any surgery done in the last two years?			☐ Yes	☐ No
Have you ever had a joint replacement (eg. hip, knee)? If so, when:			☐ Yes	□ No
Have you had any serious injuries to the head, neck, or back?			☐ Yes	□ No
Are you taking any prescription or non-prescription medications?		☐ Yes	□ No	
Name of Medication What is it taken for		1		
Have you ever had an adverse reaction to	n any of the following? (Please check	the hox and specify if	needed).	
	Freezing   Latex	the box and specify if	necucuj.	
			<u> </u>	
Have you ever had an adverse reaction to	o any other medication or substance?		☐ Yes	☐ No
If yes, please specify:				
Have you ever been advised against talif	og a specific type of medication?		□ Ver	□ Na
Have you ever been advised against takir	ig a specific type of medication?		☐ Yes	□ No
Please check the box below if you have o	r had any of the following conditions:	•		
☐ A.I.D.S./H.I.V.	☐ Congenital Heart Lesions	_	d Pressure	
Alcohol or Drug Abuse	Cold sores	☐ Kidney Di		
☐ Anemia	☐ Diabetes	☐ Liver Dise		
☐ Arthritis	F / * * *			
☐ Arthritis ☐ Artificial heart valve	☐ Epilepsy/Seizures	☐ Mitral Va	lve Prolapse	
<ul><li>☐ Arthritis</li><li>☐ Artificial heart valve</li><li>☐ Asthma</li></ul>	☐ Epilepsy/Seizures ☐ Fainting/Dizzy Spells	☐ Mitral Va ☐ Pacemak	lve Prolapse er	
<ul><li>☐ Arthritis</li><li>☐ Artificial heart valve</li><li>☐ Asthma</li><li>☐ Breathing problems</li></ul>	<ul><li>□ Epilepsy/Seizures</li><li>□ Fainting/Dizzy Spells</li><li>□ Glaucoma</li></ul>	☐ Mitral Va ☐ Pacemak ☐ Rheumat	lve Prolapse er ic/Scarlet Feve	
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