New Patient History

We are pleased to welcome you to our office. Please complete the form below. The following information is necessary to enable us to provide you with your best dental care. All information disclosed is confidential.

First Name_____Last Name_____
Current address_____
Phone(Home)_____Phone (Mobile)_____
Physician's Name and Phone Number_____

Do you have or have you ever had any of the following conditions?

	Yes	No		Yes	No
Allergies (eg. Penicillin, sulphur, codeine, latex, metal) If so please list:			Arthritis		
Artificial Joints (eg. Hip or knee replacement)			Cancer or tumor		
Bone Disorders(eg. Osteoporosis, Pagets disease, cancer of bone)			Diabetes		
Epilepsy or other Neurological Disorder			Fainting or dizziness		
Hepatitis B or C			HIV/ AIDS		
Heart Problems (eg. Heart attack, angina, stroke, murmur)			High or low blood pressure		
Heart Surgery (eg, By-pass, valve replacement, pacemaker)			Kidney or liver disease		
Mental health issues. If so please explain under other medical conditions.			Radiation to head or neck		
Respiratory problems			Sinus problems		
Have you ever taken a bisphosphonate?(actonel, zometa, fosamax)			Do you bruise or bleed easily?		
Do you smoke or use other forms of tobacco?			Are you or suspect you may be pregnant?		
Are you taking blood thinners?			Are there any other medical conditions that you would like us to be aware of?		

Please list any medications you currently take:

Other medical conditions:

Consent For Services

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with these procedures. I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee may apply.
I am aware that payment is required on the day of treatment. We also provide a preventative recall program that offers a call service to our patients.

_____ _____
Patient Signature Date of Signature