PATIENT INFORMATION

DATE _____ / _____ / _____
M D Y

PATIENT IS A(N): ❑ ADULT ❑ CHILD ❑ ADULT UNDER GUARDIANSHIP Health Card # _____

Name _____ Nickname _____ ❑ Dr. ❑ Mrs. ❑ Ms. ❑ Mr.
LAST FIRST INITIAL

Home Address _____
STREET CITY PROVINCE POSTAL CODE

Home Phone _____ Cellular _____ Email _____

Date of Birth _____ / _____ / _____ Age _____ Sex _____ Marital Status _____
M D Y

Family Physician _____ Phone _____

Medical Specialist *(if presently under care)* _____ Phone _____

OCCUPATION: _____

Employed By _____ Phone _____ Ext. _____

Spouse Employed By _____ Phone _____ Ext. _____

DENTAL INSURANCE: ❑ YES ❑ NO

Primary Insurance Co. Name _____ Certificate # _____

Group Policy # _____ Certificate # _____

Secondary Insurance Co. Name _____ Certificate # _____

Group Policy # _____ Certificate # _____

PERSON RESPONSIBLE FOR ACCOUNT: ❑ Self ❑ Other Name _____

Address _____

Home Phone _____ Business Phone _____ Cell _____

IN CASE OF EMERGENCY: Please notify _____ Relationship _____

Home Phone _____ Business Phone _____ Cell _____

Is any family or relative a patient at our office? _____ How did you hear about our office? _____

DENTAL HISTORY Reason for today's visit _____

Former Dentist _____ City/Prov _____

Date of last dental visit _____ Date of last dental X-rays _____

Are you interested in discussing - ❑ Implants ❑ Crowns ❑ Fillings ❑ Night Guards ❑ Whitening ❑ Cosmetic Options ❑ Dentures

Check (X) if you have had any of the following:

- ❑ Acid Reflux
- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Chew on one side of mouth
- ❑ Cigarette, pipe or cigar smoking
- ❑ Cosmetic problem
- ❑ Clicking or popping jaw
- ❑ Difficulty freezing
- ❑ Dry mouth
- ❑ Fingernail biting
- ❑ Food collection between the teeth
- ❑ Foreign objects
- ❑ Grinding teeth
- ❑ Gums swollen or tender
- ❑ Jaw pain or tenderness
- ❑ Lip or cheek biting
- ❑ Loose or broken teeth / fillings
- ❑ Mouth breathing
- ❑ Mouth pain, brushing
- ❑ Non-fluoridated water
- ❑ Non-fluoridated toothpaste
- ❑ Orthodontic treatment
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Sensitivity treatment
- ❑ Sensitivity to hot / cold
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sleep apnea
- ❑ Snoring
- ❑ Sores or growths in your mouth
- ❑ History of dental trauma/injury

How often do you floss? _____

How often do you brush? _____

Rate your smile from 1-10 _____

MEDICAL HISTORY

SHADED AREAS FOR OFFICE USE ONLY

MEDICAL ALERT	CONDITION:	PREMEDICATION:	ALLERGIES:	ANAESTHESIA:

ALLERGIES - ***Please check off any medications you are allergic to or you have reacted adversely to***

❑ Amoxicillin	❑ Clindamycin	❑ Local Anesthetic	❑ Aspirin	❑ Epinephrine
❑ Penicillin	❑ Azithromycin	❑ Ibuprofen	❑ Sulpha	❑ Other _____
❑ Erythromycin	❑ Tetracycline	❑ Codeine	❑ Latex	_____

MEDICAL HISTORY - ***Please check off all of the following conditions you presently have, or have had.***

Have you been under Doctor's care in the past two years? ❑ Yes ❑ No If yes, why? _____

Are you currently taking, or have taken medications, pills or drugs in the past two years? ❑ Yes ❑ No

Are you presently taking any natural supplements (e.g. vitamins, herbs, or essential oils?) ❑ Yes ❑ No

Have you been hospitalized in the past two years? ❑ Yes ❑ No If yes, why? _____

Have you had any type of surgery? ❑ Yes ❑ No What and when? _____

When walking, do you ever have to stop because of pain in your chest or shortness of breath? ❑ Yes ❑ No

When was your last complete physical examination? _____

Do you smoke or chew tobacco? ❑ Yes ❑ No

Are you currently in good health? ❑ Yes ❑ No

Have you ever been warned about anaesthetic risks? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

CURRENT MEDICATIONS

_____

_____

_____

attach list if necessary

_____

MEDICAL CONDITIONS - ***Please check off all of the following conditions you presently have, or have had.***

❑ Malignant Hyperthermia	❑ Fainting or Dizziness	❑ Cold sores	❑ Asthma
❑ Transdermal Nicotine Patches	❑ Anemia	❑ Blood Disorders	❑ Hay Fever
❑ High Blood Pressure / Hypertension	❑ Cardiac Arrest / Heart Attack	❑ Circulation Problems	❑ Sinus Trouble
❑ Low Blood Pressure	❑ Swelling of Feet/ankles/Hands	❑ Hemophilia	❑ Emphysema
❑ Heart Failure	❑ Drug or Alcohol Addiction	❑ Cancer	❑ Frequent Cough
❑ Congenital Heart Lesion	❑ Rheumatic Fever	❑ Chemotherapy/Radiation	❑ Lung Disease
❑ Artificial Heart Valve	❑ Diabetes or Hypoglycemia	❑ X-Ray/Cobalt Treatment	❑ Bronchitis
❑ Heart Pacemaker	❑ Arthritis/Rheumatism	❑ Scarlet Fever	❑ Tuberculosis
❑ Heart Surgery	❑ Epilepsy or Seizures	❑ Kidney Trouble	❑ Thyroid Disease
❑ Heart Murmur	❑ Glandular Disorders	❑ Ulcers	❑ Glaucoma
❑ Mitral Valve Prolapse	❑ Psychiatric Care	❑ Liver Disease	❑ Acid Reflux
❑ Chest Pain	❑ Mental/Nervous Disorders	❑ Hepatitis A (infec.)	❑ Head/Neck Injuries
❑ Angina Pectoris	❑ AIDS / HIV Positive	❑ Hepatitis B (serum)	❑ Other
❑ Shortness of Breath	❑ HPV	❑ Hepatitis C	_____
❑ Stroke	❑ Herpes	❑ Yellow Jaundice	

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic procedures and treatment, including local anaesthetic, as required, achieving the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

☐ Patient ☐ Parent ☐ Guardian Date _____ Signature _____