

WELCOME

In an effort to serve you better, we would ask that you complete the following. Please print.

PATIENT INFORMATION

NAME	_____				
	FIRST				LAST
ADDRESS	_____				
	STREET	APT	CITY	PROV	POSTAL CODE
DATE OF BIRTH	_____		HOME PHONE	_____	
	m/d/yr		WORK PHONE	_____	
			CEL PHONE	_____	

EMERGENCY CONTACT

FAMILY DOCTOR

name

phone number

REFERRED BY

FINANCIAL INFORMATION

METHOD OF PAYMENT CASH___ CHEQUE___ CREDIT CARD___
Person responsible for financial matters SELF___ SPOUSE___ PARENT/GUARDIAN___

Driver's License: _____ Social Insurance # _____

PRIMARY INSURANCE

Employer/ Policy _____ Ins Yr. End _____
Insurance Company _____
Policy _____ Certificate _____ ID/SIN # _____
_____ % _____ %
Coverage Basic Major ___ % Ortho

SECONDARY INSURANCE

Employer/ Policy Holder _____ Ins Yr. End _____
Insurance Company _____
Policy _____ Certificate _____ ID/SIN # _____
_____ % _____ %
Coverage Basic Major ___ % Ortho

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 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 Self/Parent/Guardian

Print name

Date

MEDICAL HISTORY

(this information will remain confidential)

1. Are you presently under the care of a physician? If so explain _____
2. Have you ever been hospitalized? _____
3. Are you taking any drugs or medications at this time?
 - a.) Drug _____
 - b.) Drug _____
 - c.) Drug _____
4. Have you ever had any adverse effects to any of the following:
Antibiotic ___ Penicillin ___ Sulfonamide ___ Other ___
Aspirin ___ Barbiturates (sleeping pills) ___ Codeine ___ Darvon ___
___ Local Anaesthetic ___ None ___
5. Have you ever been 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 smoke? How much per day? _____
9. Do you bruise easily or have prolonged bleeding? _____
10. Have you fainted, had shortness of breath or chest pains? _____
11. **WOMEN** Are you pregnant? ___ Using birth control ___ Reached menopause ___

12. Do you have or have you ever had any of the following?

___ A.I.D.S.	___ Epilepsy	___ High/Low Blood Pressure
___ Anemia	___ Glandular disorders	___ H.I.V. Positive
___ Angina	___ Head/Neck injuries	___ Hodgkin's Disease
___ Anorexia	___ Heart disease/attack	___ Hyper (hypo) Glycemia
___ Arthritis/Rheumatism	___ Heart Murmur	___ Hypertension
___ Artificial joints (hip/Knee)	___ Heart pacemaker/surgery	___ Jaundice
___ Asthma	___ Heart rhythm disorder	___ Kidney disease
___ Blood disorders	___ Hepatitis A/B/C	___ Liver disease
___ Bronchitis	___ Herpes	___ Leukemia
___ Bulimia	___ Psychiatric disorders	___ Lung Disease
___ Cancer	___ Radiation/Chemotherapy	___ Malignant hyypothermia
___ Circulation problems	___ Sinus trouble	___ Mental/nervous disorder
___ Congenital heart lesions	___ Thyroid disease	___ Mitral valve prolapse
___ Cortisone/steroid	___ Venereal Disease	___ Organ transplant/implant
___ Diabetes	___ Rheumatic/ Scarlet fever	___ Sickle Cell disease
___ Drug/Alcohol dependence	___ Stomach/intestinal problems	___ Stroke
___ Cortisone/steroid	___ Tuberculosis	___ Ulcers
___ Emphysema		

13. CHILDREN Have you recently had any of the following (approximate date)

- ___ Chicken Pox ___ Measles ___ Mumps ___ Strep Throat ___ Tonsillitis

DENTAL HISTORY

1. What is the reason for today's visit? Emergency ___ Examination ___ Other ___
2. How frequently do you see a dentist? 3-6mos ___ Annually ___ Other ___
Last x- _____
3. When was your last dental visit? _____
ray? _____
Floss? _____
Use anti-bacterial rinse? _____
4. How often do you brush your teeth per day? _____
5. Are your teeth sensitive to ___ Cold ___ Sweets ___ Heat ___ Other ___
6. Do your gums bleed when: ___ Brushing ___ Flossing ___ Never
7. Do your gums feel 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 anaesthetic freezing _____ Any complications? _____
13. Are you satisfied with your teeth?
Specify _____
14. Have you ever had any problems with previous dental treatments? Specify _____
15. Have you ever had any of the following: ___ Bridgework ___ Crowns or caps
___ Full or partial Dentures ___ Orthodontic (braces) ___ Periodontal (Gums) ___ Root Canal