Patient Information

Salutation

○ Mr. ○ Mrs. ○ Ms. ○ Dr. ○ Other _____ **Date of Birth** _____

First Name _____ **Last Name** _____

Registering for a child? ○ Yes ○ No

Person responsible for account _____

Other parental consent required ○ Yes ○ No

Mother's Name _____ **Business Tel** _____

Father's Name _____ **Business Tel** _____

Contact Information

Email _____ **Home Phone** _____ **Work Phone** _____

Street Address _____ **City** _____

Province _____ **Postal Code** _____

In case of emergency, please notify:

Name _____ **Relation** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Contact Options

I prefer appointment reminders by ○ Phone ○ SMS (TEXT) ○ Email

Whom may we thank for referring you? _____

Are any other members of your family patients at our practice? ○ Yes ○ No

Please list all family members _____

Insurance Information

○ Yes, insurance applies to me ○ No, insurance does not apply to me

Name of insured/subscriber _____

Date of Birth _____ **Patient's relationship to subscriber** ○ Self ○ Spouse ○ Child

Place of Employment _____ **Insurance Company** _____

Policy/Group # _____ **Certificate/ID #** _____

I authorize release to my dental benefits plan administrator information contained in claims and/or predeterminations

○ Yes

Medical History

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by Doctor/Patient confidentiality. The Dentist will review the questions and explain any that you do not understand. Please complete the entire form.

Are you being treated for any medical condition at the present or any time within the past year?

○ Yes ○ No ○ Not sure/maybe

When was your last medical checkup? _____

Has there been any change in your general health in the past year?

○ Yes ○ No ○ Not sure/maybe Details: _____

Are you taking any prescription, non-prescription medications, or herbal supplements?

○ Yes ○ No ○ Not sure/maybe

Please list and provide dosages. If there is insufficient room, please bring a written list of all your medications to your first appointment.

_____

Do you have any allergies?

○ Yes ○ Medications ○ Latex/rubber products Other: _____

○ No ○ Not sure/maybe

Have you ever had a peculiar or adverse reaction to any medicines or injections?

○ Yes ○ No ○ Not sure/maybe Details: _____

Do you have or have you ever had asthma?

○ Yes ○ No ○ Not sure/maybe Details: _____

Do you have or have you ever had any heart or blood pressure problems?

○ Yes ○ No ○ Not sure/maybe Details: _____

Medical History *(Continued)*

Do you have or have you ever had an artificial heart valve, 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 Details: _____

Are you being treated for any medical condition at the present or any time within the past year?

○ Yes ○ No ○ Not sure/maybe Details: _____

Do you have a prosthetic or artificial joint?

○ Yes ○ No ○ Not sure/maybe Details: _____

Do you have any conditions which may affect your immune system (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?

○ Yes ○ No ○ Not sure/maybe Details: _____

Have you ever had hepatitis, jaundice, or liver disease?

○ Yes ○ No ○ Not sure/maybe Details: _____

Do you have a bleeding problem or bleeding disorder?

○ Yes ○ No ○ Not sure/maybe Details: _____

Have you ever been hospitalized for any illnesses or operations?

○ Yes ○ No ○ Not sure/maybe Details: _____

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

○ Chest pain/angina	○ Heart Attack	○ Heart Murmur	○ Drug/Alcohol Dependency
○ Osteoporosis Medications	○ Stroke	○ Arthritis	○ Seizures
○ Mitral Valve Prolapse	○ Cancer	○ Steroid Therapy	○ Thyroid Disease
○ Shortness of Breath	○ Pacemaker	○ Diabetes	○ Stomach Ulcers
○ Rheumatic Fever	○ Lung Disease	○ Tuberculosis	○ Kidney Disease

Are there any conditions/diseases not listed that you have or have had?

○ Yes ○ No ○ Not sure/maybe Details: _____

Are there any diseases/medical problems that run in your family (e.g. diabetes, cancer, heart disease, etc.)?

○ Yes ○ No ○ Not sure/maybe Details: _____

Do you smoke or chew tobacco products?

○ Yes ○ No ○ Not sure/maybe Details: _____

Are you nervous during dental treatment?

○ Yes ○ No ○ Not sure/maybe Details: _____

Medical History *(Continued)*

For women only: Are you pregnant or breastfeeding?

○ Yes ○ No ○ Not sure/maybe What is your expected delivery date? _____

Dental History

Do you have any specific dental concerns? Please list:

_____

_____

_____

_____

_____

When was your last dental appointment? (Mm/dd/yyyy) _____

How often do you see the dentist?

○ Not Applicable ○ Every 3 months ○ Every 4 months ○ Every 6 months ○ Only when something is bothering me

Is there anything about the appearance of your teeth that you would like to change?

_____

_____

_____

_____

Have you ever whitened (bleached) your teeth?

○ Yes ○ No ○ Not sure/maybe Details: _____

Do you feel uncomfortable or self-conscious about the appearance of your teeth?

_____

_____

_____

Have you been disappointed with the appearance of previous dental work?

_____

_____

_____