

Welcome

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

Patient Information

A parent or guardian will be responsible for decisions on my treatment Yes No

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: ____/____/____ Home Tel. (____) _____ Work Tel. (____) _____
D M Y

Cell Phone _____ E-mail _____

Emergency Contact: _____ Tel. (____) _____

Family Doctor: _____ Tel. (____) _____

Referring Doctor: _____ Tel. (____) _____

Financial Information

Method of payment: Cash Cheque Credit Card Insurance Other

Person responsible for financial matters: Self Spouse Parent/Guardian Other

IF DIFFERENT FROM ABOVE

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: ____/____/____ Home Tel. (____) _____ Work Tel. (____) _____
D M Y

PRIMARY INSURANCE

Ins. Company: _____ Tel. (____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID#: _____

Max Cov. _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

SECONDARY INSURANCE

Ins. Company: _____ Tel. (____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID#: _____

Max Cov. _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

PATIENT INFORMATION

MEDICAL/DENTAL HISTORY

Medical History (this information will remain confidential) Date _____

YES NO

- 1. Are you presently under the care of a physician? If so, explain.
2. Have you ever been hospitalized? Explain.
3. Are you taking any drugs or medication at this time?
4. Have you ever had any adverse effect to any of the following: Antibiotic- Penicillin, Sulfonamide, Other, Aspirin, Barbiturates, 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 bruise easily or have prolonged bleeding?
9. Do you smoke? How much per day?
10. Have you ever fainted, had shortness of breath or chest pains?
11. WOMEN Are you pregnant? Yes No Using birth control? Yes No Reached menopause? Yes No
12. Do you have or have you ever had any of the following? Please check appropriate boxes.
13. CHILDREN Have you recently had any of the following (approximate date)?

Dental History

- 1. What is the reason for today's visit? Emergency Examination Other
2. How frequently do you see a dentist? 3-6 months Annually Other
3. When was your last dental visit? Last X-Ray?
4. How often do you brush per day? Floss? Use anti-bacterial rinse?
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? Yes No Specify
13. Have you ever had any of the following: Bridgework Crowns or Caps Full or Partial Dentures Orthodontic (braces) Periodontal (Gums) Root Canal
14. Are you satisfied with your teeth? Specify

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