WELCOME TO OUR OFFICE

NAME: ______________________________ AGE: ______ DATE OF BIRTH: __________
Last First Initial (dd/mm/yy)

TEL (HOME): ______________ EXT: ______

ADDRESS: ______________________________ TEL (CELL): ______________ EXT: ______
No. and Street City Prov Postal code

REASON FOR TODAY'S VISIT:

EMAIL ADDRESS: ______________ ☐ EXAMINATION ☐ OTHER ______________

☐ EMERGENCY

FAMILY PHYSICIAN: ______________ TEL: ______________ EXT: ______

PERSON RESPONSIBLE FOR ACCOUNT:

☐ SELF

☐ OTHER NAME: ______________ TEL: ______________ EXT: ______

ADDRESS: ______________________________

YOUR OCCUPATION: ______________ EMPLOYED BY: ______________ TEL: ______________ EXT: ______

SPOUSE'S OCCUPATION: ______________ EMPLOYED BY: ______________ TEL: ______________ EXT: ______

IF A CHILD (Parent or Guardian's Name): ______________ ADDRESS (If different): ______________

IN CASE OF EMERGENCY NOTIFY: ______________ RELATIONSHIP: ______________

TEL: ______________ EXT: ______

Names of other family members who are patients at our office: ______________________________

Who may we thank for referring you to our office? ______________________________

DENTAL INSURANCE ☐ YES ☐ NO

PRIMARY SUBSCRIBER

NAME: ______________________________

DOB (dd/mm/yy): __________ // __________ / __________

EMPLOYER: ______________________________

INSURANCE COMPANY: ______________________________

GROUP#: ______________ ID#: ______________

RELATIONSHIP TO INSURED: ______________________________

SECONDARY SUBSCRIBER

NAME: ______________________________

DOB (dd/mm/yy): __________ // __________ / __________

EMPLOYER: ______________________________

INSURANCE COMPANY: ______________________________

GROUP#: ______________ ID#: ______________

RELATIONSHIP TO INSURED: ______________________________

MEDICAL HISTORY

1. Are you presently under the care of a physician for any medical condition? ☐ Yes ☐ Maybe/Not Sure ☐ No

   If yes, please specify: ______________ Physician's Name: ______________ Tel: ______________

2. Are you taking or have you recently taken any prescription or non-prescription drugs? ☐ Yes ☐ Maybe/Not Sure ☐ No

   If yes, please list them: ______________________________

3. Do you or have you ever had any heart or blood pressure problems (e.g. heart attack, heart murmur, mitral valve prolapse, angina, heart pacemaker, high or low blood pressure)? ☐ Yes ☐ Maybe/Not Sure ☐ No

4. Do you experience shortness of breath or chest pains when taking a walk or climbing stairs? ☐ Yes ☐ Maybe/Not Sure ☐ No

5. Have you ever been hospitalized for any serious illness or operations? ☐ Yes ☐ Maybe/Not Sure ☐ No

   Specify: ______________________________

6. Have you ever had treatment for a tumor or growth (e.g. radiation, surgery, chemotherapy)? ☐ Yes ☐ Maybe/Not Sure ☐ No

7. Have you ever experienced an allergic or other bad reaction to a medication, injection, material or food of any kind (e.g. penicillin, aspirin or local anesthetics, "dental freezing", metals, latex)? ☐ Yes ☐ Maybe/Not Sure ☐ No

   Specify: ______________________________

8. Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut? ☐ Yes ☐ Maybe/Not Sure ☐ No

9. Do you have any conditions that could affect your immune system (e.g. AIDS, HIV positive, leukemia, etc.)? ☐ Yes ☐ Maybe/Not Sure ☐ No

10. Do you have or have you ever had jaundice, hepatitis (A, B or C), or liver disease? ☐ Yes ☐ Maybe/Not Sure ☐ No

11. Do you vape, smoke, chew tobacco, or use a transdermal nicotine patch? ☐ Yes ☐ Maybe/Not Sure ☐ No

12. Do you have any hearing difficulties? ☐ Yes ☐ Maybe/Not Sure ☐ No

13. Do you have or have you ever had any blood disorders (e.g. anemia, sickle cell disease, etc.)? ☐ Yes ☐ Maybe/Not Sure ☐ No

14. Do you or does any member of your family have diabetes, if so whom? ☐ Yes ☐ Maybe/Not Sure ☐ No

____

15. For women only: Are you taking birth control pills? ☐ Yes ☐ Maybe/Not Sure ☐ No

16. For women only: Are you pregnant or suspect you might be? ☐ Yes ☐ Maybe/Not Sure ☐ No

17. Do you have or have you ever had any of the following? Please check off any that apply.

☐ Chest Pain	☐ Asthma	☐ Breathing disorders	☐ Congenital Heart Lesions
☐ Stomach Ulcers	☐ Kidney Disease	☐ Rheumatic Heart Disease	☐ Sinus Trouble
☐ Lung Disease	☐ Rheumatic/Scarlet Fever	☐ Arthritis	☐ Glaucoma
☐ Fainting or Dizzy Spells	☐ Tuberculosis	☐ Cancer	☐ Epilepsy or Seizures
☐ Bone Muscle or Joint Disorder	☐ Stroke	☐ Alcohol Dependency	☐ Joint Replacement
☐ Mental/Nervous Disorder or Psychiatric Treatment	☐ Prosthetic Implant	☐ Drug Dependency	☐ Hypo/Hyperglycemia
☐ Bronchitis	☐ Circulation Problems	☐ Organ Transplant	☐ Thyroid Disease

18. Is there anything the dentist should know about your medical history that has not been mentioned? ☐ Yes ☐ Maybe/Not Sure ☐ No

If yes, please specify: ____

DENTAL HISTORY

Please check any of the following that apply:

☐ Bleeding gums ☐ Sensitivity to cold, hot, sweets, etc. ☐ Problem with previous dental work ☐ Swollen/tender gums

☐ Grind or clench teeth ☐ Pain in jaw joints/muscles ☐ Bad breath

1. How long since your last visit to the dentist? __________ Years __________ Months

2. Did you receive dental x-rays at that time?
☐ Yes ☐ Maybe/Not Sure ☐ No

3. Did you have your teeth cleaned?
☐ Yes ☐ Maybe/Not Sure ☐ No

4. Have you ever had local anaesthetic (freezing)?
☐ Yes ☐ Maybe/Not Sure ☐ No

Any complications? If yes, please specify:

____

5. Are you satisfied with the appearance of your teeth?
☐ Yes ☐ Maybe/Not Sure ☐ No

If not, please specify:

Colour Gaps Size Shape Chips Other

6. How often do you Brush? __________ Floss? __________

7. Type of toothbrush:
☐ Soft ☐ Medium ☐ Hard

8. Have you ever received oral hygiene instruction in:

Brushing ☐ Yes ☐ Maybe/Not Sure ☐ No

Flossing ☐ Yes ☐ Maybe/Not Sure ☐ No

Other __________ ☐ Yes ☐ Maybe/Not Sure ☐ No

9. Does food routinely catch between your teeth?
☐ Yes ☐ Maybe/Not Sure ☐ No

10. Please not any other dental concerns you have:

____

INFORMED CONSENT/GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental, and oral surgery procedures and services including the use of anaesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services.

PATIENT (PARENT, GUARDIAN) SIGNATURE:

DATE: ____________
(dd/mm/yy)

IF PARENT/GUARDIAN*, PLEASE PRINT NAME:

____

*Guardian of Child or Guardian of Adult under Guardianship