

# WELCOME TO OUR OFFICE

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
Last First Initial

TEL (HOME): \_\_\_\_\_ EXT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TEL (CELL): \_\_\_\_\_ EXT: \_\_\_\_\_  
No. and Street City Prov Postal code

EMAIL ADDRESS: \_\_\_\_\_

REASON FOR TODAY'S VISIT:  
 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	SECONDARY SUBSCRIBER
NAME: _____	NAME: _____
DOB (dd/mm/yy): _____ / _____ / _____	DOB (dd/mm/yy): _____ / _____ / _____
EMPLOYER: _____	EMPLOYER: _____
INSURANCE COMPANY: _____	INSURANCE COMPANY: _____
GROUP#: _____ ID#: _____	GROUP#: _____ ID#: _____

## MEDICAL HISTORY

- 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: \_\_\_\_\_
- Are you taking or have you recently taken any prescription or non-prescription drugs?  Yes  Maybe/Not Sure  No  
If yes, please list them: \_\_\_\_\_
- 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
- Do you experience shortness of breath or chest pains when taking a walk or climbing stairs?  Yes  Maybe/Not Sure  No
- Have you ever been hospitalized for any serious illness or operations?  Yes  Maybe/Not Sure  No  
Specify: \_\_\_\_\_
- Have you ever had treatment for a tumor or growth (e.g. radiation, surgery, chemotherapy)?  Yes  Maybe/Not Sure  No
- 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.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Chest Pain                                       | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Breathing disorders     | <input type="checkbox"/> Congenital Heart Lesions |
| <input type="checkbox"/> Stomach Ulcers                                   | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Sinus Trouble            |
| <input type="checkbox"/> Lung Disease                                     | <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Glaucoma                 |
| <input type="checkbox"/> Fainting or Dizzy Spells                         | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Epilepsy or Seizures     |
| <input type="checkbox"/> Bone Muscle or Joint Disorder                    | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Alcohol Dependency      | <input type="checkbox"/> Joint Replacement        |
| <input type="checkbox"/> Mental/Nervous Disorder or Psychiatric Treatment | <input type="checkbox"/> Prosthetic Implant      | <input type="checkbox"/> Drug Dependency         | <input type="checkbox"/> Hypo/Hyperglycemia       |
| <input type="checkbox"/> Bronchitis                                       | <input type="checkbox"/> Circulation Problems    | <input type="checkbox"/> Organ Transplant        | <input type="checkbox"/> 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 note 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:

IF PARENT/GUARDIAN\*, PLEASE PRINT NAME:

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\*Guardian of Child or Guardian of Adult under Guardianship