Welcome to Our Office

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

Patient Name:_____
Last Initial First

Address:_____
Street Apt. City Prov. Postal Code

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

E-mail:_____ Health Card #:_____

Emergency Contact:_____ Tel.(____)_____

Family Doctor:_____ Tel.(____)_____

Preferred Appointment Times:□Morning □Afternoon □Evening □Any Time □M □T □W □T □F □S

WHO REFERRED YOU TO OUR OFFICE? _____

FINANCIAL INFORMATION Method of payment: Cash□ Cheque□ Credit Card□ Insurance □ Other□

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

INSURANCE INFORMATION

Ins. Company: _____Tel.(____)_____

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

Policy#:_____ Certificate#:_____

DENTAL HISTORY

1. What is the reason for today's visit? □ Emergency □Examination □Other
2. How frequently do you see a dentist? □3-6months □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? .....□Yes □No
8. Do you have bad breath or a bad taste in your mouth? .....□Yes □No
9. Do your jaw crack, pop or grate when you open widely? .....□Yes □No
10. Do you grind or clench your teeth? .....□Yes □No
11. Do you have food catch between your teeth? .....□Yes □No
12. Have you ever had local anaesthetic (freezing)? .....□Yes □No
13. Have you ever had any problems with previous dental treatments? .....□Yes □No
14. Have you ever had any of the following:□Bridgework □Crowns or Caps □Full or Partial Dentures
    □ Orthodontics (braces) □Periodontal (Gums) □Root Canal

15. Are you satisfied with your teeth? Specify……..□Yes □No

16. Are you nervous during dental treatment? .....□Yes □No

17. Do you Snore? ……□Yes □No

MEDICAL HISTORY **(This information will remain confidential)**

1. Are you presently under the care of a physician? If so, explain _____□Yes □No

2. Have you ever been hospitalized? Explain. _____□Yes □No

3. Are you taking any drugs or medication at this time? _____□Yes □No

A) Drug_____ Reason _____

B) Drug_____ Reason _____

C) Drug_____ Reason _____

4. Have you ever had any adverse effect 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? _____□Yes □No

6. Have you ever taken prolonged medical or non-medical drugs? Which? _____□Yes □No

7. Do you suffer from any allergies (hay fever, latex etc.)? Which? _____□Yes □No

8. Do you bruise easily or have prolonged bleeding? ……□Yes □No

9. Do you smoke? How much per day?_____.....□Yes □No

10. Have you ever fainted, had shortness of breath or chest pains.....□Yes □No

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? PleaseV appropriate boxes. **NONE**□

□ A.I.D.S □ Anemia □ Angina pectoris □ Anorexia nervosa □ Arthritis/rheumatism

□ Artificial heart valve □ Artificial joints (hip, knee) □ Asthma □ Blood disorders

□ Bronchitis □Bulimia □ Cancer □ Circulation problems □Congenital heart lesions

□ Cortisone/steroid □ Diabetes □Drug/Alcohol dependence

□ Emphysema □ Epilepsy or seizures □ Glandular disorders □ Glaucoma

□Head/Neck injuries □ Heart disease/attack □ Heart murmur □ Heart peacemaker/surgery

□ Heart rhythm disorder □ Hepatitis A,B,C □ Herpes □High/Low blood pressure

□ H.I.V. Positive □Hodgkins disease □ Hyper (Hypo) Glycaemia

□ Hypertension □ Jaundice □ Kidney disease □ Kidney disease

□ Liver disease □ Leukemia □ Lung disease □ Malignant hyperthermia

□ Mental/nervous disorder □ Mitral valve prolapse □ Organ transplant/implant □ Psychiatric Treatment

□Radiation/Chemotherapy □Rheumatic/Scarlet fever □ Sickle Cell disease □ Sinus trouble

□Stomach/intestinal prob. □ Stroke □ Thyroid disease □ Tuberculosis

□Ulcers □Sexually Transmitted Infection □Other _____

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

□ Chicken Pox _____ □ Measles _____ □ Mumps _____ □ Strep Throat _____

□ Tonsillitis _____ □ NONE

_____ _____ _____

Signature □Self □Parent/Guardian Print Name Date