Welcome TO OUR OFFICE

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In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. All information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. PLEASE ANSWER EVERY QUESTION ON **BOTH SIDES.**

PERSONAL INFORMATION

Date _____
Day Month Year

Name _____ Date of Birth _____ Age _____

Address _____ Home Phone _____

City _____ Cell Phone _____

Postal Code _____ Office Phone _____

Email _____ Sex _____

Occupation _____ MaritalStatus _____

Name of Employer _____ Medical Doctor _____

Name of person responsible for this account _____

Do you have dental insurance? _____

Whom may we thank for referring you? Name _____

MEDICAL HISTORY

		Yes	No
1.	Have you ever had any serious illness, operation, or been hospitalized?	☐	☐
	If yes, explain _____		
2.	Are you currently under the care of a physician for any problem?.....	☐	☐
	If yes, explain _____		
3.	Have you had a medical examination within the last year?	☐	☐
	If yes, any problems? _____		
4.	Are you presently taking any medicine, drugs, or pills?.....	☐	☐
	If yes, what? _____		
5.	Do you have or have you ever had any of the following? (Circle).....	☐	☐

Rheumatic Fever	Liver Disease (Jaundice, Hepatitis)	Thyroid Disease
Heart Trouble	Kidney Disease	Lung Disease
High Blood Pressure	Diabetes	Asthma
Heart Murmur	Epilepsy	Blood Disorders
Venereal Disease	Radiation or X-ray Therapy	Anemia
Mental or Nervous Disease	Gastrointestinal Disease	Cancer
Joint Replacement	AIDS	Sinusitis

Other _____

6.	Do you have any allergies?	☐	☐
	Explain _____		
7.	Are you allergic to any medicine or drug?	☐	☐
	If yes, explain _____		
8.	Have you ever been told that you need antibiotics before dental treatment?.....	☐	☐
9.	Have you ever had freezing (local anaesthetic) in your mouth?	☐	☐
	Any ill effects from it?.....	☐	☐

PLEASE TURN OVER

		Yes	No
10.	Have you reacted adversely to any of the following?		
	Penicillin or other antibiotics	☐	☐
	Sedatives, barbiturates, or sleeping pills	☐	☐
	Aspirin	☐	☐
	Codeine	☐	☐
	Other	☐	☐
11.	Do you bleed abnormally?	☐	☐
12.	Do you bruise easily?	☐	☐
13.	Have you ever fainted? When? _____	☐	☐
14.	Do you have shortness of breath?	☐	☐
15.	Do you have any chest pains?	☐	☐
16.	Do your ankles ever swell?	☐	☐
17.	Have you gained or lost excessive weight recently?	☐	☐
18.	Have you had an increased thirst, appetite or frequency of urination?	☐	☐
19.	Is there any history of family disease?	☐	☐
20.	Is there anything that the dentist should know regarding your medical history that has not been mentioned?	☐	☐
	Explain _____		
21.	To the best of your knowledge, are you in good health?	☐	☐
22.	WOMEN: Are you pregnant?	☐	☐
	If yes, in what stage of pregnancy? _____		
23.	How often do you brush & floss? _____		

DENTAL HISTORY

1.	Have you ever had a complete dental examination with a full series of dental x-rays within the past 3 years?	☐	☐
2.	Last dental visit? _____ What was done? _____		
3.	Have you had any extractions?	☐	☐
	If yes, did you experience prolonged bleeding after?	☐	☐
4.	Have you ever had any of the following dental treatments? (Circle)		
	Root Canal Orthodontics Full or Partial Denture		
	Periodontal (Gums) Crowns or Caps Bridgework		
5.	Are you aware of bad breath or bad taste in your mouth?	☐	☐
6.	Are you happy with your smile?	☐	☐
7.	Would you like to have whiter teeth?	☐	☐
8.	Have you ever had a bad experience at the dentist?	☐	☐
	Explain _____		
9.	What is your current dental problem?		

_____

_____

OFFICE POLICY (Please read)

1. Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore at least 2 business days NOTICE must be given if cancellation is absolutely necessary.
2. Office policy is that services are paid for at each visit as they are performed. However, in certain circumstances arrangements for payment may be made by consulting the doctor.
3. Regarding insurance: All professional services are charged directly to the patient and patients are personally responsible for payment of bills on their accounts. We will prepare any necessary forms or reports to help collect your benefits from insurance companies.
4. Please note that our office collects, uses and discloses your personal information in accordance with the office privacy policies, which directly follow all relevant federal and provincial laws, including PHIPA and RHPA.

Patient's Signature _____