



## PATIENT INFORMATION

### Welcome to Our Dental Office!

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the entire form.

#### PERSONAL INFORMATION

Dr.  Mr.  Mrs.  Miss  Ms

First Name: \_\_\_\_\_

Status:  Single  Married  Child  Other

Home Address: \_\_\_\_\_

City: \_\_\_\_\_

Email: \_\_\_\_\_

Work Tel: \_\_\_\_\_

Employer: \_\_\_\_\_

Physician: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Why have you decided to change dental offices? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Last Name: \_\_\_\_\_

Mid: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth (DD/MM/YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Apt: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Home Tel: \_\_\_\_\_

Cell: \_\_\_\_\_

Occupation: \_\_\_\_\_

Physicians Phone No: \_\_\_\_\_

#### INSURANCE INFORMATION 1

Name of insured if different from above: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Division (If applicable): \_\_\_\_\_

Do you have Secondary Insurance?  No  Yes

Date of Birth of Insured (DD/MM/YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Policy/Group: \_\_\_\_\_

Certificate ID#: \_\_\_\_\_

**(Please fill out the next section)**

#### INSURANCE INFORMATION 2

Name of insured if different from above: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Division (If applicable): \_\_\_\_\_

Date of Birth of Insured (DD/MM/YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Policy/Group: \_\_\_\_\_

Certificate ID#: \_\_\_\_\_

#### EMERGENCY CONTACT

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Tel: \_\_\_\_\_

#### MEDICAL HISTORY

Are you being treated for any medical condition at the present or have you been treated within the last year? YES NO

If yes, specify: \_\_\_\_\_

When was your last medical check-up? \_\_\_\_\_

Has there been any change in your general health in the past year?

Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:

Drug: \_\_\_\_\_

Reason: \_\_\_\_\_

Drug: \_\_\_\_\_

Reason: \_\_\_\_\_

Drug: \_\_\_\_\_

Reason: \_\_\_\_\_

Drug: \_\_\_\_\_

Reason: \_\_\_\_\_

YES NO

Do you have any allergies?  Latex  Other: \_\_\_\_\_  YES  NO

Have you had an unusual reaction to any drugs or medicines?  YES  NO

Penicillin  Sulfonamide  Aspirin  Codeine  Local Anesthetic  Other: \_\_\_\_\_

Have you ever taken cortisone or steroid medication?  YES  NO

Do you have any sinus problems?  YES  NO

Do you have or have you ever had any heart problems?  YES  NO

Do you have a pacemaker?  YES  NO

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?  YES  NO

Do you or have you ever had jaundice, hepatitis or liver disease?  YES  NO

Do you have a bleeding problem or bruise easily? Are you on blood thinner?  YES  NO

Do you have any conditions that could affect your immune system ego AIDS, HIV infection, Leukemia etc?  YES  NO

Do you smoke? If yes, how much? \_\_\_\_\_  YES  NO

Have you ever been hospitalized for any serious illnesses or operations?  YES  NO

Do you have any prosthetic or artificial joints?  YES  NO

Do you have or have you ever had any of the following?

<input type="checkbox"/> Chest Pain/Angina	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Asthma
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemotherapy/Radiation
<input type="checkbox"/> Psychiatric Disorder	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Drug/Alcohol Dependency		

For females: Are you pregnant or breast feeding?  YES  NO

Any other conditions or problems of which the dentist should be aware of?  YES  NO

If yes, please list: \_\_\_\_\_

**DENTAL HISTORY**

When was your last dental visit? \_\_\_\_\_

When did you last have dental x-rays? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

Have you been seeing a dentist regularly?  YES  NO

Do any of your teeth ache?  YES  NO

Have you ever been advised to take antibiotics before dental appointments?  YES  NO

Do your gums bleed when you brush?  YES  NO

Do you have any pain when you chew?  YES  NO

Do you feel that you have bad breath?  YES  NO

Have you ever been in a motor vehicle accident or experienced any blows to your jaw?  YES  NO

Have you ever had a dental implant surgery?  YES  NO

If yes, who performed the surgery and when was it done? \_\_\_\_\_

Are you being followed-up by a dental specialist?  YES  NO

Please list anything else not mentioned above regarding your past dental history: \_\_\_\_\_

**GENERAL CONSENT STATEMENT**

I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge, and not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

Signature of Patient

DD/MM/YYYY

Reviewed by Dentist

DD/MM/YYYY