Personal Information

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Prof. ❑Ms. ❑Miss.

Name: ____
Home Address: ____
City: _______________ Province: _______________ Postal Code: ____________________
Email: _______________________________________
Tel: H:(____)______-_________ W:(____)______-_________ ext: _______
Cell: (____)______-_________
Preferred Contact Method: ____________________________________
Occupation: _____________________________
Birthdate: M: _________ D: _________ Yr: _________
Person responsible for this account: ____________ Address (if different from above):
____
In case of emergency whom may we contact?: _____________________________________
Are other family members patients at our office: ___________________________________
Who can we thank for referring you?: ____
Drivers Lic.# ____
This is required for any narcotic analgesics (new Provincial requirement)

Insurance Information

Do you have insurance? ❑Yes ❑No Name of Insured:
____
Employer: _______________________
Insurance Company Name: ____
Policy or Group Number: _____________________ I.D or Certificate number: ___________

Medical History

Medical Doctor's Name:
____
Telephone Number:
____
Address:
____

Are you being treated by a medical doctor now? Yes No
If Yes, for what reason?

Are you taking any medicine at the present time? Yes No
If Yes, what?

Have you ever taken cortisone or steroids? Yes No
If yes, when?

Are you sensitive or allergic to any modification? Yes No
If Yes, what?

Have you ever been hospitalized or had any surgical operations? Yes No
If Yes, list the reasons and dates:

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please check if applicable)

- ❑ HIV Positive/Aids
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Arthritis
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Epilepsy or Seizures
- ❑ Do you bruise easily?
- ❑ High/ Low Blood Pressure
- ❑ Stroke
- ❑ Allergies or hives
- ❑ Heart Murmur
- ❑ Kidney Disease
- ❑ Diabetes (Sugar Disease)
- ❑ Pacemaker
- ❑ Thyroid Disease
- ❑ Hay fever
- ❑ Rheumatic Fever
- ❑ Anemia
- ❑ Ulcers (Stomach or intestinal)
- ❑ Cancer
- ❑ Have you ever had jaundice?
- ❑ Do you have difficulty swallowing?
- ❑ Do you bleed excessively from cuts to wounds?
- ❑ Do you have severe headaches?
- ❑ Do you have frequent severe headaches?
- ❑ Are you under abnormal stress? (For example martial, business, or social)
- ❑ Do you have any disease, condition, or problem not listed above? If Yes, explain:
- ❑ Do you drink alcohol? How many drinks a day __________ Week __________
- ❑ Do you smoke?

FEMALES

- ❑ Are you Pregnant? Due Date: ____________________
- ❑ Are you taking oral contraceptives (Birth Control)

Dental History

1. Is there a dental problem you would like treated immediately? Yes No

2. If yes, specify.

3. Have you been seeing a dentist regularly? Yes No

4. Date of:
   Last visit
   Last Hygiene

5. Have you recently had dental x-rays? Yes No

6. If yes, when:

7. Are there any growths or sore spots in your mouth? Yes No

8. Do you bleed when brushing or eating, do you suffer from pain or swelling of your gums? Yes No

9. Have you had undesirable reactions to local or general anesthetics? (For example, Novocaine or Gas) Yes No

10. Do you grind your teeth while you're awake or asleep? Yes No

11. Are any of your teeth sensitive to cold/hot, sweets or pressure? Yes No

12. Do you use dental floss, proxabrush or stimudents? Yes No

13. How often?

14. How often do you brush your teeth?

15. Are you dissatisfied with the appearance of your teeth? Yes No

16. Do you feel that you have bad breath? Yes No

17. Does your jaw click or pop when you chew? Yes No

18. Do you snore? Yes No

19. What qualities do you look for in a dentist?

Financial Policy

I assume responsibility for all fees associated with treatment and fully understand that payment is expected on the date of treatment.

Consent For Treatment

This is to clarify that, I am providing consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general and local anesthetic as indicated and I accept the Financial Policy above.

______________________________ Signature

______________________________ Date