

WELCOME TO OUR OFFICE

The following information is required to enable us to provide you with the best possible dental care. All the information you provide will be kept strictly confidential.

Chart #
Medical Alert

PATIENT INFORMATION

The patient is an: ADULT CHILD ADULT UNDER GUARDIANSHIP
Dr. Mr. Mrs. Ms. Miss Name of Guardian: _____
Name: _____
Last First Initial
Preferred Name: _____ Spouse's Name: _____
Address: _____
Street Apt. City Prov. Postal Code
Tel: () _____ () _____ () _____
Home Work ext. Cell
E-Mail: _____ Preferred Contact Home Cell
Method: Work E-mail
Date of Birth: ____/____/____ Sex: M F Marital Status: _____
dd mm yy
Emergency Contact: _____ Relationship: _____ Tel: () _____
Family Physician: _____ Tel: () _____
Are other family members patients here? Yes No Names: _____
Whom may we thank for referring you? _____

CHILDREN ONLY:

School: _____ Grade: _____ Favorite Toy _____
Brothers/Sisters: _____

EMPLOYER INFORMATION

Employer: _____ Spouse's Employer: _____
Position/Title: _____ Position/Title: _____
Tel: () _____ Tel: () _____

FINANCIAL INFORMATION

Personal responsible for account: Self Spouse Other _____
Method of payment: Cash Visa MasterCard AMEX Debit Insurance
Name as it appears on card: _____
Card number: _____ Expiry date: _____
Driver's Lic. #: _____ S.I.N #: _____

PRIMARY DENTAL INSURANCE

Ins. Name: _____
Ins. Company: _____ Tel: () _____
Employer/Policy Holder: _____ Ins. Yr. End: _____
Policy#: _____ Certificate#: _____ ID/SIN# _____
Max. Cov. _____ %Coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic _____

SECONDARY DENTAL INSURANCE

Ins. Name: _____
Ins. Company: _____ Tel: () _____
Employer/Policy Holder: _____ Ins. Yr. End: _____
Policy#: _____ Certificate#: _____ ID/SIN# _____
Max. Cov. _____ %Coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic _____



MEDICAL HISTORY

- Are you being treated for any medical condition at present or in the past year? If yes, please specify?

- Have you been hospitalized in the past year? _____
- What is the date of your last medical examination? _____
- Are you presently taking any medications (prescription/over-the-counter/herbal)? If yes, please list:
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
- Have you ever had a reaction to any kind of medicine? If yes, please specify:
Penicillin Sulfa Aspirin Barbiturates Codeine Local Anesthetic
Nitrous Oxide Other _____
- Do you have any allergies (medication, latex, hay fever, other)? If yes, please specify:

- Do you bruise easily, or bleed excessively? _____
- Do you smoke? How much per day? _____
- WOMEN: Are you pregnant? Yes No Breastfeeding? Yes No Using birth control? Yes No Reached menopause? Yes No
- Do you have or ever had any of the following? Please appropriate boxes

	Yes	No		Yes	No		Yes	No
A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Glandular disorders	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia nervosa	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Malignant hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Head/neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	Mental/nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease/attack	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints (hip, knee)	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant/implant	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart pacemaker/surgery	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	Radiation/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High/Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. positive	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal prob.	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkin's disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Hyper (Hypo) glycemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroid	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol dependence	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>
- CHILDREN: Have you recently had any of the following (approximate date)?
Measles _____ Chicken Pox _____ Tonsillitis _____
Mumps _____ Strep Throat _____ Other _____
- Are there other medical conditions we should know about? _____

DENTAL HISTORY

- What is the reason for today's visit? Emergency Examination Other _____
- How frequently do you see a dentist? 3-6 months Annually Other _____
- When was your last dental visit? _____ Last dental cleaning? _____ Last X-Ray? _____
- How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
- Are your teeth sensitive to: Cold Sweets Heat Pressure Other _____
- Do your gums bleed when: Brushing Flossing Never _____
- Do your gums feel swollen or tender? _____
- Do you have bad breath or a bad taste in your mouth? _____
- Do your jaws crack, pop or grate when you open widely? _____
- Do you grind or clench your teeth? _____
- Does food catch between your teeth? _____
- Have you ever had local anesthetic (freezing)? _____
Any complications? Yes No Specify _____
- Have you ever had any problems with previous dental treatment? Specify _____
- Have you ever had any of the following: Bridgework Crowns or Caps
Full or Partial Dentures Orthodontics (braces) Periodontal (Gums) Root Canal
- Are you satisfied with your teeth? Specify _____
- Any other dental concerns? _____

General Release

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the release of medical information from my medical doctor or other health provider as is required by your office. I will advise your office if there are any changes to my health status or any other information I have provided. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

X _____
Signature Patient Parent/Guardian

_____ Print Name

_____ Reviewed by

_____ Date