CONFIDENTIAL PATIENT INFORMATION

Date _____

NAME _____

First Last Initial

How would you prefer to be addressed?_____

Please list other family members attending this office

_____

How did you hear about our office? _____

ADDRESS _____

Street Unit# City Prov. Postal Code

HOME PHONE _____ BUSINESS _____ OTHER _____

EMAIL _____ FAX _____

DATE OF BIRTH _____ SEX_____ OCCUPATION_____

Day/ Month/ Year

EMPLOYED BY _____

EMERGENCY CONTACT _____

NAME & DATE OF BIRTH OF INSURED MEMBER (if other than self):

_____

PERSON RESPONSIBLE FOR ACCOUNT: SAME AS ABOVE □ OR _____

1. DATE OF LAST MEDICAL EXAMINATION _____

2. NAME OF PHYSICIAN _____ PHONE _____

3. IS YOUR PHYSICIAN TREATING YOU FOR ANYTHING NOW? IF YES, PLEASE SPECIFY

□ YES □ NO _____

4. ARE YOU ON MEDICATION? IF YES PLEASE LIST MEDICATION □ YES □ NO _____

_____

_____

_____

_____

5. DO YOU HAVE DRUG ALLERGIES? □ YES □ NO

IF YES PLEASE SPECIFY _____

_____

_____

6. HAVE YOU EVER HAD OR BEEN TREATED FOR?

Respiratory Disease	□ YES	□ NO	Epilepsy	□ YES	□ NO
Hepatitis	□ YES	□ NO	*Last Seizure:		
Tuberculosis	□ YES	□ NO	*Triggers:		
Low Blood Pressure	□ YES	□ NO	Rheumatic Fever	□ YES	□ NO
High Blood Pressure	□ YES	□ NO	Anemia	□ YES	□ NO
Stroke	□ YES	□ NO	Liver Problems	□ YES	□ NO
Heart Disease	□ YES	□ NO	Abnormal Bleeding	□ YES	□ NO
Nervous Problems	□ YES	□ NO	Ulcer	□ YES	□ NO
Scarlet Fever	□ YES	□ NO	Shortness of Breath	□ YES	□ NO
Sinus	□ YES	□ NO	Arthritis	□ YES	□ NO
Herpes	□ YES	□ NO	Dizzy Spells	□ YES	□ NO

Please complete other side

Continued from other side

Thyroid Problems	□ YES □ NO	Blood Disorders	□ YES □ NO
Diabetes	□ YES □ NO	Asthma	□ YES □ NO
□ Diet or □ Insulin Controlled		Kidney Problems	□ YES □ NO
Normal Sugar Level		Drug Dependence	□ YES □ NO
AIDS or HIV Positive	□ YES □ NO	Chest Pains	□ YES □ NO
Psychiatric Problem	□ YES □ NO	Disease of Eyes, Ears,	
Heart Murmur	□ YES □ NO	Nose or Throat	□ YES □ NO
Latex Allergy	□ YES □ NO	Cancer	□ YES □ NO
Hip, Knee, Joint replacement	□ YES □ NO	General Allergies	□ YES □ NO

7. ARE YOU PREGNANT? □ YES □ NO MONTH _____

8. HAVE YOU BEEN HOSPITALISED FOR ANY PERIOD OF TIME IN THE LAST 12 MONTHS? □ YES □ NO
IF YES FOR WHAT REASON? _____

9. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH? PLEASE SPECIFY (INCLUDE ANY SURGERIES)_____

_____

_____

1. Are you having discomfort at this time? □ YES □ NO Please specify _____

_____

2. Have you been under regular care by a dentist? □ YES □ NO Last visit?_____

3. Previous dentist? _____ What was done at this time? _____

_____

5. Do your gums feel tender or swollen?	□ YES □ NO
6. Are you aware of any lump or swelling in your mouth?	□ YES □ NO
7. Do you wear a full or partial denture?	□ YES □ NO
8. Do you have dental implants?	□ YES □ NO
9. Have you ever had a problem with local or general anesthetic?	□ YES □ NO
10. Are you tense during dental visits?	□ YES □ NO

11. Would you be interested in improving the appearance of your teeth?

12. Describe in your own words what would you like done to your teeth_____

_____

13. Do you currently experience?

Unexplained nose bleed □ YES □ NO	Loose teeth □ YES □ NO	Bad breath □ YES □ NO
Spaced or crooked teeth □ YES □ NO	Sensitive teeth □ YES □ NO	Earache □ YES □ NO
Unsatisfactory dentures □ YES □ NO	Missing teeth □ YES □ NO	Gagging □ YES □ NO
Popping or clicking	Bleeding gums □ YES □ NO	
in the jaws joints □ YES □ NO	Sore gums □ YES □ NO	

CONSENT:

I, _____, consent to the performing of the dental procedures agreed to be necessary or advisable for myself or _____ , and furthermore, I am assuming responsibility for all fees associated with those procedures to be paid in full at the time of the appointment.

Signature _____ **Date**_____

I authorize release, to my insuring company/ plan administrator, of the information contained in claims submitted electronically.

Signature of Patient _____ **Parent/ Guardian**_____

Witness _____ **Date** _____