Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help!

Patient Information *(CONFIDENTIAL)*

Patient #: _____

Date: _____

Name: _____ *Birthdate:* _____ *Phone #:* _____

Address: _____ *City:* _____ *Prov:* _____ *Postal Code:* _____

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency? _____ *Phone:* _____

Dental Insurance Information:

Name of Insured: _____ *Relationship to Patient:* _____
Birthdate: _____ *Name of Employer:* _____ *Union or Local #:* _____
Insurance Company: _____ *Group #:* _____ *Policy/ID #:* _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No* | ***IF YES, PLEASE COMPLETE THE FOLLOWING:***

Name of Insured: _____ *Relationship to Patient:* _____

Birthdate: _____ *Name of Employer:* _____ *Union or Local #:* _____

Insurance Company: _____ *Group #:* _____ *Policy/ID #:* _____

Patient Medical History:

Physician: _____ *Office Phone:* _____ *Date Last Seen:* _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain? _____	☐	☐
3. Are you taking any medication(s) Including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Do you snore?	☐	☐

7. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Any Metals (e.g. Nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Adhesives	☐	☐
Other (please list) _____		
8. <u>WOMEN ONLY:</u>		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

-Over Please-

9. Do you have or have you had any of the following:	*Yes*	*No*		*Yes*	*No*		*Yes*	*No*
High Blood Pressure	☐	☐	*Heart Disease*	☐	☐	*Chest Pains*	☐	☐
Heart Attack	☐	☐	*Cardiac Pacemaker*	☐	☐	*Easily Winded*	☐	☐
Rheumatic Fever	☐	☐	*Heart Murmur*	☐	☐	*Stroke*	☐	☐
Swollen Ankles	☐	☐	*Angina*	☐	☐	*Hay Fever/Allergies*	☐	☐
Fainting/Seizures	☐	☐	*Frequently Tired*	☐	☐	*Tuberculosis*	☐	☐
Asthma	☐	☐	*Anemia*	☐	☐	*Radiation Therapy*	☐	☐
Low Blood Pressure	☐	☐	*Emphysema*	☐	☐	*Glaucoma*	☐	☐
Epilepsy/Convulsions	☐	☐	*Cancer*	☐	☐	*Recent Weight Loss*	☐	☐
Leukemia	☐	☐	*Arthritis*	☐	☐	*Liver Disease*	☐	☐
Diabetes	☐	☐	*Joint Replacement/Implant*	☐	☐	*Respiratory Problems*	☐	☐
Kidney Diseases	☐	☐	*Hepatitis/Jaundice*	☐	☐	*Mitral Valve Prolapse*	☐	☐
AIDS or HIV Infection	☐	☐	*Sexually Transmitted Disease*	☐	☐	*Other:* _____		
Thyroid Problem	☐	☐	*Stomach Troubles/Ulcers*	☐	☐	_____		

Patient Dental History:

Name of Previous Dentist: _____ *Office Phone:* _____ *Date Last Seen:* _____

	Yes	*No*		*Yes*	*No*
1. Are you under medical treatment now?	☐	☐	*8. Do you have frequent headaches?*	☐	☐
2. Do your gums bleed while brushing or flossing?	☐	☐	*9. Do you clench or grind your teeth?*	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/food?	☐	☐	*10. Do you bite your lips or cheeks frequently?*	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐	*11. Have you ever had any difficult extractions in the past?*	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐			
6. Have you had any head, neck or jaw injuries?	☐	☐	*12. Have you ever had any prolonged bleeding following extractions?*	☐	☐
7. Have you experienced any of the following problems in your jaw?			*14. Have you received oral hygiene instructions regarding the care of your teeth and gums?*	☐	☐
a) Clicking	☐	☐			
b) Pain (joint, ear, side of face)	☐	☐	*15. Do you wear dentures or partials?*	☐	☐
c) Difficulty in opening or closing	☐	☐	*16. Do you like your smile?*	☐	☐
d) Difficulty in chewing	☐	☐			

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

I consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependents dental care.

X_____

Signature of Patient (or parent if minor)