



Today's date: \_\_\_\_\_

**Patient Information** (all information is strictly confidential and will remain with this office)

Name: \_\_\_\_\_  
Last First Prefer to be called

Address: \_\_\_\_\_  
Street City Prov Postal Code

Telephone: \_\_\_\_\_  
Home Work Cell

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Month / day / year

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about our office? ☐ Facebook ☐ Google ☐ Yellow Pages ☐ Friend/Family ☐ Blog ☐ Existing Patients

**Medical Information**

Medical doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Do you consider yourself to be in good health: \_\_\_\_\_

Are you presently under the care of a medical doctor: ☐ Yes ☐ No If yes please specify \_\_\_\_\_

Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins: \_\_\_\_\_

Do you have any allergies or have you had any reaction to (medications, anesthetics, metals, latex, antibiotics, pain killers, dairy, etc.): \_\_\_\_\_

Do you have to take antibiotics prior to dental work? If yes, why? \_\_\_\_\_

Have you had heart surgery? If yes, please specify: \_\_\_\_\_

Do you have any artificial prosthesis (Joints, heart valve, etc)? If yes please specify: \_\_\_\_\_

Do you have abnormal bleeding? ☐ Yes ☐ No Do you become breathless easily? ☐ Yes ☐ No

**Do you have or have had any of the following:**

|                         |                                                          |                 |                                                          |                  |                                                          |
|-------------------------|----------------------------------------------------------|-----------------|----------------------------------------------------------|------------------|----------------------------------------------------------|
| High blood pressure     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmur     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Digestive disorders     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus problems          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low blood pressure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart trouble   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Hiv/aids</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Head or Neck injuries   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney trouble  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Venereal Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nervous problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis type  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiation therapy       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest pain      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol/drug dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Antidepressants  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herpes                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke           | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Others: \_\_\_\_\_

Do you smoke? ☐ Yes ☐ No If so how much? \_\_\_\_\_ Do you take recreational drugs? ☐ Yes ☐ No  
Women: Are you taking Birth Control Pills? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

**This is to certify that I, the undersigned, consent to the performing or the procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.**

**Signed:** \_\_\_\_\_

### **Account Information**

Person financially responsible for the account: \_\_\_\_\_

### **Dental History**

Are you having any discomfort at this time? If yes please specify: \_\_\_\_\_

Have you been under the regular care of a dentist? ☐ Yes ☐ No How long since your last dental visit: \_\_\_\_\_  
What was done at that time? \_\_\_\_\_

Do your gums feel tender or swollen? ☐ Yes ☐ No

Is there often bleeding when you floss? ☐ Yes ☐ No

Have you ever been given local anesthetic (freezing)? ☐ Yes ☐ No

Have you ever had general anesthetic? ☐ Yes ☐ No

Are you aware of any lump or swelling in your mouth? ☐ Yes ☐ No

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

Are you anxious to keep your natural teeth? ☐ Yes ☐ No

Are you tense during your dental visits? ☐ Yes ☐ No

Are you interested in a method to calm your nerves? ☐ Yes ☐ No

Describe what you would like done with your teeth: \_\_\_\_\_

### **Do you currently experience any of the following?**

Loose teeth ☐ Yes ☐ No Ear ache ☐ Yes ☐ No Spaced or crooked teeth ☐ Yes ☐ No

Bad Breath ☐ Yes ☐ No Gagging ☐ Yes ☐ No Unexplained nose bleeds ☐ Yes ☐ No

Missing Teeth ☐ Yes ☐ No Sore Gums ☐ Yes ☐ No Popping or clicking of the jaw ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No Headache ☐ Yes ☐ No Unsatisfactory Dentures ☐ Yes ☐ No

### **Office Policy**

Your appointment time will be reserved especially for you. If you are unable to keep your appointment we require 48 hours notice, otherwise, it may be necessary to charge for the time lost.

I understand that I am ultimately responsible for the total fees associated with the treatment performed.

**Date:** \_\_\_\_\_ **Patient/ Guardian signature:** \_\_\_\_\_