



Welcome to Our Dental Office

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the entire form.

PERSONAL INFORMATION

Dr. Mr. Mrs. Miss Ms Name: _____
Name you would like to be called: _____
SIN #: _____ Date of Birth (DD/MM/YYYY): _____
Home Tel: _____ Office Tel: _____ Ext: _____
Address: _____ Apt: _____
City: _____ Postal Code: _____
Occupation: _____ Employer: _____
Email: _____ Physician: _____
Previous Dentist: _____ Physician's Phone No: _____
Why have you decided to change dental offices? _____

How did you hear about us? _____

INSURANCE INFORMATION 1

Name of Insured if different from above: _____
Insurance Company: _____ Birthdate of Insured (DD/MM/YYYY): _____
Division if applicable: _____ Policy/Group: _____
Employer: _____ Certificate ID #: _____
Do you have secondary Insurance? _____

INSURANCE INFORMATION 2

Name of Insured if different from above: _____
Insurance Company: _____ Birthdate of Insured (DD/MM/YYYY): _____
Division if applicable: _____ Policy/Group: _____
Employer: _____ Certificate ID #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Tel: _____

MEDICAL HISTORY

	YES	NO
Are you being treated for any medical condition at the present or have you been treated within the last year? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____		
When was your last medical check-up? _____		
Has there been any change in your general health in the past year? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:	<input type="checkbox"/>	<input type="checkbox"/>
Drug: _____ Reason: _____		
Drug: _____ Reason: _____		
Drug: _____ Reason: _____		

SEE REVERSE

	YES	NO
Do you have any allergies? <input type="checkbox"/> Latex <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an unusual reaction to any drugs or medicines? _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfonamide <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Other: _____		
Have you ever taken cortisone or steroid medication? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sinus problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had any heart problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you or have you ever had jaundice, hepatitis or liver disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bleeding problem or bruise easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia etc? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? If yes, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized for any serious illnesses or operations? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any prosthetic or artificial joints? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had any of the following?		
<input type="checkbox"/> Chest Pain/Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Arthritis		
<input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Stomach Ulcers		
<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy/Radiation <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> Drug/Alcohol Dependency		
For females: Are you pregnant or breast feeding? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any other conditions or problems of which the dentist should be aware of? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____		

DENTAL HISTORY

	YES	NO
When was your last dental visit? _____		
When did you last have dental x-rays? _____		
How often do you brush your teeth? _____		
How often do you floss your teeth? _____		
Have you been seeing a dentist regularly? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth ache? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been advised to take antibiotics before dental appointments? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you brush? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any pain when you chew? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you have bad breath? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been in a motor vehicle accident or experienced any blows to your jaw? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a dental implant surgery? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who performed the surgery and when was it done? _____		
Are you being followed-up by a dental specialist? _____	<input type="checkbox"/>	<input type="checkbox"/>
Please list anything else not mentioned above regarding your past dental history: _____		

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

Signature of patient

D D / M M / Y Y Y Y

Reviewed by dentist

D D / M M / Y Y Y Y