Welcome

Please fill out this form completely.
If you have any questions or need assistance, please ask us.

Patient Information *(Confidential)*

Date _____

Name _____ Birthdate (d/m/y) _____

Address _____ City _____ Prov. _____

Postal Code_____ Home Phone _____ Work Phone _____

Cell _____ Email _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone_____

What do we need to know about you to ensure that your visits here are positive experiences? _____

_____

What are your long term goals regarding the condition of your mouth? _____

Has anyone ever recommended pre-medication prior to dental treatment? Reason _____

What prompted your decision to come here today? _____

How often do you go to the dentist? _____When was your last hygiene appointment? _____

Responsible Party

Name of person responsible for account *(if different from above)* _____

Address *(if different from above)* _____

Phone *(if different from above)* _____

Insurance Information

We will happily submit your claim forms and submit them on your behalf.
We ask that you clear your account at each visit.

PRIMARY

Name of Insured _____ Birthdate (d/m/y)_____

Relationship to patient _____Employer _____

Name of Insurance Company _____

Group Policy # _____ Division # _____ ID/Certificate # _____

ADDITIONAL

Name of Insured _____ Birthdate (d/m/y)_____

Relationship to patient _____Employer _____

Name of Insurance Company _____

Group Policy # _____ Division # _____ ID/Certificate # _____

Please continue on second page…

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Y	N
Are you under medical treatment now?	☐	☐
Have you been hospitalized for any surgical operation or a serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s)? _____		
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Are you wearing contact lenses?	☐	☐
Are you allergic to or have any reactions to the following?		
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (eg. nickel, mercury, etc.)	☐	☐
Latex rubber	☐	☐
Other (please list) _____	☐	☐
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more that 3 weeks)?	☐	☐
Women only:		
Are you or do you think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking any oral contraceptives?	☐	☐

Do you have, or have you had any of the following?

	Y	N
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐
Chest Pain	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Persistent Diarrhea	☐	☐
Undiagnosed Rash	☐	☐
Other _____	☐	☐

Patient Dental History

Names of Previous Dentist and Location _____ Date of Last Exam _____

	Y	N
Do your gums bleed during brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/food?	☐	☐
Are your teeth sensitive to sweet or sour liquids/food?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following jaw problems:		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty chewing	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement? _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you like your smile?	☐	☐

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 party payors and/or health practitioners. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's.

Signature of patient (or parent/guardian if a minor) _____

Doctor's comments _____

_____ Signature _____ Date _____