



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: _____
Mobile Tel: _____ 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

Are you being treated for any medical condition at the present or have you been treated within the last year? _____ YES NO

If yes, specify: _____

When was your last medical check-up? _____

Has there been any change in your general health in the past year? _____ YES NO

Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____

YES NO

Do you have any allergies? Latex Other: _____

Have you had an unusual reaction to any drugs or medicines? _____

Penicillin Sulfonamide Aspirin Codeine Local Anesthetic Other: _____

Have you ever taken cortisone or steroid medication? _____

Do you have any sinus problems? _____

Do you have or have you ever had any heart problems? _____

Do you have a pacemaker? _____

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? _____

Do you or have you ever had jaundice, hepatitis or liver disease? _____

Do you have a bleeding problem or bruise easily? _____

Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia etc? _____

Do you smoke? If yes, how much? _____

Have you ever been hospitalized for any serious illnesses or operations? _____

Do you have any prosthetic or artificial joints? _____

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

Chest Pain/Angina Heart Attack High Blood Pressure Stroke Tuberculosis Arthritis
 Emphysema Epilepsy Thyroid Disease Diabetes Asthma Stomach Ulcers
 Kidney Disease Cancer Chemotherapy/Radiation Psychiatric Disorder Drug/Alcohol Dependency

For females: Are you pregnant or breast feeding? _____

Any other conditions or problems of which the dentist should be aware of? _____

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? _____

Do any of your teeth ache? _____

Have you ever been advised to take antibiotics before dental appointments? _____

Do your gums bleed when you brush? _____

Do you have any pain when you chew? _____

Do you feel that you have bad breath? _____

Have you ever been in a motor vehicle accident or experienced any blows to your jaw? _____

Have you ever had a dental implant surgery? _____

If yes, who performed the surgery and when was it done? _____

Are you being followed-up by a dental specialist? _____

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

DD / MM / YYYY

Reviewed by dentist

DD / MM / YYYY