

Date: _____

Legal Full Name: _____ Male/ Female I like to be called : _____

Home address : _____ City /Province : _____

Postal code / Zip Code: _____ Marital Status: _____ Date of birth (dd/mm/yy): _____

E-mail address: _____

Home phone: _____ Work phone: _____ Cell/ Pager number : _____

Your Employer: _____ Occupation: _____

Insurance Co. _____ Group# _____ ID# _____ Name _____ DOB _____

2nd Insurance Co. _____ Group# _____ ID# _____ Name _____ DOB _____

How did you hear about us or whom can we thank for referring you? _____

MEDICAL HISTORY

Have you ever had, or been treated for any of the following medical problems? Please circle.

- | | |
|---------------------------------|---|
| Y N Heart attack/S troke | Y N Mitral Valve Prolapse |
| Y N Hepatitis / Jaundice | Y N High /Low Blood Pressure |
| Y N Epilepsy /Seizures/Fainting | Y N Abnormal bleeding /Anemia |
| Y N Cancer/C hemotherapy | Y N Kidney problems |
| Y N Psychiatric problems | Y N Diabetes |
| Y N Tuberculosis | Y N Drug/Alcohol abuse |
| Y N AIDS / HIV | Y N Anemia |
| Y N Depression | Y N Artificial Valves Y N Angina |
| Y N Anxiety | Y N Congenital Cyanotic Heart defects _____ |
| Y N Liver Disease | Y N Surgery: Type &Date: _____ |
| Y N Arthritis | Y N Asthma |
| Y N Herpes/cold sores | Y N Artificial limbs or joints |

Have you ever been treated for any other illness not listed above? ___Yes ___ No If yes, please explain : _____

Are you currently taking prescription medications, including herbal remedies? If yes, please list below: _____

Do you have any allergies to any medications or substances ? ___Yes ___ No If yes, please explain: _____

Have you recently been under the care of a physician? ___Yes ___ No If so, for what? _____

Name of physician: _____ Phone #: _____

Last visit with physician: _____ Current Health: ___ Excellent ___ Good ___ Fair ___ Poor

Is there any condition not listed that we should know about? ___Yes ___ No If yes, Please explain: _____

DENTAL HISTORY

Why have you come to the dentist today? New Patient Exam Emergency Other Explain: _____

Date of your last dental visit: _____ Previous Dentist's Name: _____

Do you have any areas of concern? _____

How often do you brush your teeth? _____ Floss? _____ Do your gums bleed? Yes No

Are your teeth sensitive to cold sweets heat Do your gums feel tender/swollen? Yes No

Do you have bad breath or a bad taste in your mouth? Yes No

Do you grind/clench your teeth, or notice any clicking/popping noises? Yes No

Do you wear a night guard? Yes No Do you suffer from frequent migraines? Yes No

Do you need to be pre medicated with antibiotics prior to dental treatment? Yes No

Do you smoke or use chewing tobacco? Yes No

Do you snore? Yes No Do you suffer from Sleep Apnea/ C-pap? Yes No

Are you interested Cosmetic treatments such as Botox or Juvederm? Yes No

Women Only: Are you pregnant? Yes No If yes, how many months? _____

In case of an emergency, is there someone in the area we can call?

Name: _____ Phone #: _____

Relationship to you: _____

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I agree to pay for all services rendered by this dental centre. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission to use any photos taken for lecturing, publishing or educational purposes with my identity removed.

Your appointment time is reserved especially for you. If you are unable to keep this time we ask for 48 hours notice so we may accommodate another patient, otherwise a \$50 fee may be charged.

Date: _____ Signature: _____

PRIVACY POLICY

It is our policy to keep all information provided by you confidential. Information you have provided us is used for Diagnostic and billing insurance purposes only. We also collect information in order to know you better. This is to improve both our service to you and your experience with us. We will share and provide information on a need basis to insurance companies, specialists or health care providers as part of the care we provide to you.

Please sign this to acknowledge and accept this privacy policy.

Date: _____ Signature: _____