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Today's date:______________________________

PATIENT INFORMATION

Name: Miss/Ms./Mrs./Mr./Dr.
____ Date of Birth: ______________________

Address: ____________________________________City:____________________________

Postal Code: _________________________________Email:___________________________

Phone: Home ______________Business:___________Cell:____________________________

Employer: ____________________________________Occupation:______________________

Spouse's Name: _______________________________Phone number: ___________________

Physician's name and Phone: ____________________Former Dentist: _________________

Referred by: ____

Who should we contact in the event of an emergency?

Name: _______________________________________Phone: __________________________

DENTAL INSURANCE

YES NO

Name of Insurance Company: ______________________Dependent Number:_______________

Group/Policy Number: __________________________SIN/ID/Employee Number of Employee:______

Name of Subscriber:_____________________________Subscriber's Date of Birth:___________

Your relationship to Subscriber:______________________

Do you have two insurance plans? YES NO

Name of Insurance Company: ______________________Dependent Number:_______________

Group/Policy Number: __________________________SIN/ID/Employee Number of Employee:______

Name of Subscriber:_____________________________Subscriber's Date of Birth:___________

Your relationship to Subscriber:______________________

MEDICAL HISTORY

☐ Yes ☐ No 1. Are you now under the care of a physician? If so, what is the condition being treated?

____

☐ Yes ☐ No 2. Have you ever had any serious illness or operation? If so, what was the illness/operation and where?

____

☐ Yes ☐ No 3. Have you even been hospitalized? If so, what was the problem and when?

____

☐ Yes ☐ No 4. Are you taking any drug or medicine? If so, please list:

____

☐ Yes ☐ No 5. Are you allergic to or have you reacted adversely to any drug or medicine (e.g. dental freezing, antibiotics, pain killers etc.) If so, what happened?

____

6. Do you have or had any of the following diseases or problems?

☐ Yes ☐ No Rheumatic fever or rheumatic heart disease
☐ Yes ☐ No Congenital heart disease
☐ Yes ☐ No Cardiovascular disease (e.g. heart trouble, heart attack, high blood pressure, arteriosclerosis– hardening of the arteries, stroke)
☐ Yes ☐ No Chest pains or shortness of breath
☐ Yes ☐ No Asthma, hay fever, skin rash
☐ Yes ☐ No Fainting spells or seizures (e.g. epilepsy)
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Kidney disease
☐ Yes ☐ No Liver disease or jaundice
☐ Yes ☐ No Endocrine disorder (e.g. thyroid disease)
☐ Yes ☐ No Lung or breathing disorders
☐ Yes ☐ No Gastrointestinal disease (e.g. ulcers)
☐ Yes ☐ No Nervous disorder
☐ Yes ☐ No Bone, muscle or joint disorders (e.g. osteoporosis, arthritis)
☐ Yes ☐ No Cancer
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Radiotherapy
☐ Yes ☐ No Prosthetic joints or valves
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No HIV
☐ Yes ☐ No 7. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
☐ Yes ☐ No 8. Do you bruise easily?
☐ Yes ☐ No 9. Do you have any blood disorder?
☐ Yes ☐ No 10. Do you smoke or use tobacco products? If so, how frequently and for how long?__________________
☐ Yes ☐ No 11. Women: Are you pregnant?
☐ Yes ☐ No 12. Do you have any disease or problem not listed here you think I should know about? If so, please explain:____

DENTAL HISTORY

1. How often do you: a) brush your teeth?_________________b) floss?_____________
2. Which type of brush do you use? a) manual?________________________ b) electric?__________

☐ Yes ☐ No 3. Are you presently in any dental pain?
☐ Yes ☐ No 4. Do your gums bleed?
☐ Yes ☐ No 5. Do you have difficulty chewing your food?
☐ Yes ☐ No 6. Do you clench or grind your teeth during the day or night?
If so, do you wear a night guard? ☐ Yes ☐ No
☐ Yes ☐ No 7. Do you awaken with pain in your teeth or jaw?
☐ Yes ☐ No 8. Are you aware of jaw clicking or popping while eating or yawning?
☐ Yes ☐ No 9. Do you have frequent headaches or facial pain?
☐ Yes ☐ No 10. Do you ever get food stuck between your teeth?
☐ Yes ☐ No 11. Do you have an unpleasant taste or odour in your mouth?
☐ Yes ☐ No 12. In past years have you been to a dentist on a regular basis? How often?__________________________
☐ Yes ☐ No 13. Do you have growths or swelling in your mouth? If yes, for how long?____________________________
☐ Yes ☐ No 14. Have you had your wisdom teeth removed?
☐ Yes ☐ No 15. Have you had orthodontic treatment (braces)?
☐ Yes ☐ No 16. Have you even been treated for periodontal disease?
☐ Yes ☐ No 17. Is any part of your mouth sensitive to temperature, pressure, or sweets?
☐ Yes ☐ No 18. Are you anxious or nervous about dental treatment?
☐ Yes ☐ No 19. Are you satisfied with your teeth, functionally and esthetically?
If not, what would you like to improve?____

20. Please provide any other information that you feel is relevant:____

All information you provide is strictly confidential.

Please note that insurance companies will NOT notify us of any changes to your existing insurance plan. It is your responsibility to provide us with all up to date details of your insurance policy and coverage.

Your appointment time will be reserved especially for you. If you are unable to keep your appointment, please notify us at least 48 hours in advance to avoid a cancellation fee.

This is to certify that I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to to be necessary or advisable, including the use of local anaesthetic and/or relative analgesia as indicated, and I will assume responsibility for fees associated with theses procedures. I certify that the medical information provided is accurate and up to date.

Patient's signature: ____Date: ____