Today's Date _____

Patient Information (All information is strictly confidential and will remain with this office.)

Name: _____
Last First Prefer to be called

Address: _____
Street City Prov Postal Code

Telephone: _____
Home Work Cell

Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Month / Day / Year

Employed by: _____ Occupation: _____

How did you hear about our office? _____

Whom may we thank for referring you? _____ Telephone: _____

Medical Information

Medical Doctor: _____ Telephone: _____
Date of last physical exam: _____ Do you consider yourself to be in good health? _____
Are you presently under the care of a medical doctor: _____ If yes please specify: _____
Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins:

_____

Do you have any allergies or have you had any reaction to (medications, anesthetics, metals, latex, antibiotics, pain killers, dairy, etc.):

_____

Do you have to take antibiotics prior to dental work? If yes, why? _____
Have you had heart surgery? If yes, please specify: _____
Do you have any artificial prosthesis (Joints, heart valve, etc)? If yes please specify: _____
Do you have abnormal bleeding? _____ Do you become breathless easily? _____
Do you have or have you had any of the following:

High Blood Pressure	YES ☐	NO ☐	Tuberculosis	YES ☐	NO ☐	Hepatitis Type	YES ☐	NO ☐	Hiv/Aids	YES ☐	NO ☐
Anemia	YES ☐	NO ☐	Headaches	YES ☐	NO ☐	Chest Pain	YES ☐	NO ☐	Tested	YES ☐	NO ☐
Sinus Problems	YES ☐	NO ☐	Herpes	YES ☐	NO ☐	Blood Disorders	YES ☐	NO ☐	Digestive Disorders	YES ☐	NO ☐
Low Blood Pressure	YES ☐	NO ☐	Thyroid Problems	YES ☐	NO ☐	Liver Disease	YES ☐	NO ☐	Glaucoma	YES ☐	NO ☐
Arthritis	YES ☐	NO ☐	Diabetes	YES ☐	NO ☐	Asthma	YES ☐	NO ☐	Head Or Neck Injuries	YES ☐	NO ☐
Cancer	YES ☐	NO ☐	Venereal Disease	YES ☐	NO ☐	Rheumatic Fever	YES ☐	NO ☐	Radiation Therapy	YES ☐	NO ☐
Nervous Problems	YES ☐	NO ☐	Heart Trouble	YES ☐	NO ☐	Heart Murmur	YES ☐	NO ☐	Chemotherapy	YES ☐	NO ☐
Epilepsy	YES ☐	NO ☐	Kidney Trouble	YES ☐	NO ☐	Emphysema	YES ☐	NO ☐	Antidepressants	YES ☐	NO ☐
Psychiatric Care	YES ☐	NO ☐	Stroke	YES ☐	NO ☐	Ulcer	YES ☐	NO ☐	Alcohol/Drug Dependency	YES ☐	NO ☐

Others: _____
Do you smoke? _____ If so how much? _____ Do you take recreational drugs? _____
Women: Are you taking Birth Control Pills? _____ Are you pregnant? _____

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.

Signed: _____

Account Information

Person financially responsible for the account: _____

IF THE PATIENT IS UNDER 18 YEARS OF AGE

Father's Name: _____

Father's address (if different than child): _____

Father's telephone: Home _____ Work _____ Cell _____

Mother's Name: _____

Mother's address (if different than child): _____

Mother's telephone: Home _____ Work _____ Cell _____

Who is financially responsible for the account? _____

Insurance Information

1st INSURANCE

Name of Insurance: _____ Policy# _____ Id# _____

Name of Policy Holder: _____ Date of Birth: _____ (M / D / Y) Employer: _____

Basic Services: _____ % Maximum: _____ $ Major Services: _____ % Maximum: _____ %

Recall frequency: _____ mths Scaling: _____ units Year is: _____

2nd INSURANCE

Name of Insurance: _____ Policy# _____ Id# _____

Name of Insured: _____ Date of Birth: _____ (M / D / Y) Employer: _____

Basic Services: _____ % Maximum: _____ $ Major Services: _____ % Maximum: _____ %

Recall frequency: _____ mths Scaling: _____ units Year is: _____

In Case of Emergency please notify

Name: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Address: _____

_____

Dental History

Are you having any discomfort at this time? If yes please specify: _____

_____

Have you been under the regular care of a dentist? _____

How long since your last dental visit? _____

What was done at that time? _____

Do your gums feel tender or swollen? _____

Is there often bleeding when you floss? _____

Have you ever been given local anesthetic (freezing)? _____

Have you ever had general anesthetic? _____

Are you aware of any lump or swelling in your mouth? _____

Are you satisfied with the appearance of your teeth? _____

Are you anxious to keep your natural teeth? _____

Are you tense during dental visits? _____

Are you interested in a method to calm your nerves? _____

Do you have an unpleasant taste or odor in you mouth? _____

Describe what you would like done with your teeth: _____

_____

_____

Do you currently experience any of the following:

Loose teeth	YES ☐	NO ☐	Bleeding gums	YES ☐	NO ☐
Ear ache	YES ☐	NO ☐	Headache	YES ☐	NO ☐
Spaced or crooked teeth	YES ☐	NO ☐	Bleeding gums	YES ☐	NO ☐
Bad breath	YES ☐	NO ☐	Neck pain	YES ☐	NO ☐
Unexplained nosebleed	YES ☐	NO ☐	Unsatisfactory dentures	YES ☐	NO ☐
Popping or clicking in the jaw joints	YES ☐	NO ☐	Sore gums	YES ☐	NO ☐
Missing teeth	YES ☐	NO ☐	Gagging	YES ☐	NO ☐

Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we require 48 hours' notice, otherwise, it may be necessary to charge for the time lost.

It is likely that there will be a difference in fees paid by my insurance company and charged by my dentist. I understand that I am ultimately responsible for the total fees associated with the treatment performed. Including the fees not covered by my insurance.

Date: _____ Patient/Guardian Signature: _____