PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name _____ Preferred name _____Sex_____ Birth date_____

Home phone _____Cell phone _____ E-mail _____

Address _____ City _____ Prov. _____ Postal Code _____

Employer / School _____ Occupation _____Work Phone _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____

EMERGENCY CONTACT NAME _____RELATION_____PHONE_____

DENTAL HISTORY

Reason for today's visit _____ Former Dentist Name _____

Date of last dental visit _____ Date of last cleaning _____ Date of last dental x-ray _____

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Issue with previous treatments
- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Blisters on lips or mouth
- ❑ Chew on one side of mouth
- ❑ Smoking
- ❑ Clicking or popping jaw
- ❑ Denture
- ❑ Food collection b/t teeth
- ❑ Grinding teeth
- ❑ Gums swollen or tender
- ❑ Jaw pain or tiredness
- ❑ Loose teeth or broken fillings
- ❑ Mouth breathing
- ❑ Orthodontic treatment
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Sensitivity to cold / heat / sweets

Do you have any dental related issues/concerns not listed above? _____

MEDICAL HEALTH HISTORY

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

Yes	No	
❑	❑	Cancer or tumor
❑	❑	Heart disease
❑	❑	Artificial joint or valve
❑	❑	High or low blood pressure
❑	❑	Pacemaker
❑	❑	Tuberculosis or other lung problems
❑	❑	Kidney disease
❑	❑	Hepatitis or other liver disease
❑	❑	Alcoholism
❑	❑	Blood transfusion
❑	❑	Diabetes
❑	❑	Neurologic condition
❑	❑	Epilepsy, seizures, or fainting spells
❑	❑	Emotional condition
❑	❑	Arthritis
❑	❑	Herpes or cold sores
❑	❑	AIDS or HIV positive
❑	❑	Migraine headaches or frequent headaches
❑	❑	Anemia or blood disorders
❑	❑	Abnormal bleeding after extractions, surgery, or trauma
❑	❑	Hayfever or sinus trouble
❑	❑	Allergies or hives
❑	❑	Asthma

Are you allergic to, or have you reacted adversely to:

Yes	No	
❑	❑	Latex materials
❑	❑	Penicillin or other antibiotics
❑	❑	Local anesthetics ("Novocain")
❑	❑	Codeine or other narcotics
❑	❑	Barbiturates, sedatives, or sleeping pills
❑	❑	Aspirin
❑		Other:_____

Are you taking any of the following?

❑	❑	Aspirin
❑	❑	Anticoagulants (blood thinners)
❑	❑	Antibiotics or sulfa drugs
❑	❑	High blood pressure medicine
❑	❑	Antidepressants or tranquilizers
❑	❑	Insulin, Orinase, or other diabetes drug
❑	❑	Nitroglycerin
❑	❑	Cortisone or other steroids
❑	❑	Osteoporosis (bone density) medicine
❑		Other:_____

Women:

❑	❑	May be pregnant, expected due date _____
❑	❑	Taking hormones or contraceptives

Name of your physician:_____Phone number_____

Do you have any disease, condition, or problem not listed above?_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any unpaid balance. I also consent for the office to communicate with me via telephone, Text or email.

Signature of patient (or parent) _____ Date _____