Medical History (this information will remain confidential) Date_____

	YES	NO
1. Are you presently under the care of a physician? If so, explain. _____	☐	☐
2. Have you ever been hospitalized? Explain. _____	☐	☐
3. Are you taking any drugs or medication at this time?	☐	☐

A) Drug _____ Reason _____

B) Drug _____ Reason _____

C) Drug _____ Reason _____

4. Have you ever had any adverse effect to any of the following: **Antibiotic**- Penicillin ☐, Sulfonamide ☐, Other ☐;
Aspirin ☐; **Barbiturates** (sleeping pills) ☐; **Codeine** ☐; **Darvon** ☐; **Local Anaesthetic** ☐; **NONE** ☐.

5. Have you ever been warned against using any other medications? Which? _____	☐	☐
6. Have you ever taken prolonged medical or non-medical drugs? Which? _____	☐	☐
7. Do you suffer from any allergies (hay fever, latex etc.)? Which? _____	☐	☐
8. Do you bruise easily or have prolonged bleeding?	☐	☐
9. Do you smoke? How much per day? _____	☐	☐
10. Have you ever fainted, had shortness of breath or chest pains?	☐	☐

11. **WOMEN** Are you pregnant? Yes ☐ No ☐ Using birth control? Yes ☐ No ☐ Reached menopause? Yes ☐ No ☐

12. Do you have or have you ever had any of the following? Please ✓ appropriate boxes. **NONE** ☐

☐ A.I.D.S.	☐ Cortisone/steroid	☐ High/Low Blood pressure	☐ Psychiatric disorders
☐ Anemia	☐ Diabetes	☐ H.I.V. Positive	☐ Radiation/Chemotherapy
☐ Angina pectoris	☐ Drug/alcohol dependence	☐ Hodgkin's disease	☐ Rheumatic/Scarlet fever
☐ Anorexia nervosa	☐ Emphysema	☐ Hyper (Hypo) Glycemia	☐ Sickle Cell disease
☐ Artificial Heart valve	☐ Epilepsy	☐ Hypertension	☐ Sinus trouble
☐ Arthritis/rheumatism	☐ Glandular disorders	☐ Jaundice	☐ Stomach/intestinal problems
☐ Artificial joints (hips, knees)	☐ Glaucoma	☐ Kidney disease	☐ Stroke
☐ Asthma	☐ Head/Neck injuries	☐ Liver disease	☐ Thyroid disease
☐ Blood disorders	☐ Heart disease/attack	☐ Leukemia	☐ Tuberculosis
☐ Bronchitis	☐ Heart murmur	☐ Lung disease	☐ Ulcers
☐ Bulimia	☐ Heart pacemaker/surgery	☐ Malignant hypothermia	☐ Venereal disease
☐ Cancer	☐ Heart rhythm disorder	☐ Mental/nervous disorder	☐ Other _____
☐ Circulation problems	☐ Hepatitis A/B/C	☐ Mitral valve prolapse	☐ Other _____
☐ Congenital heart lesions	☐ Herpes	☐ Organ transplant/implant	☐ Other _____

13. **CHILDREN** Have you recently had any of the following (approximate date)?

☐ Chicken Pox _____ ☐ Measles _____ ☐ Mumps _____

☐ Strep Throat _____ ☐ Tonsillitis _____ ☐ NONE

Dental History

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other _____
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other _____
3. When was your last dental visit? _____ Last X-Ray? _____
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____
6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never

	YES	NO
7. Do your gums feel swollen or tender?	☐	☐
8. Do you have bad breath or a bad taste in your mouth?	☐	☐
9. Do your jaws crack, pop or grate when you open widely?	☐	☐
10. Do you grind or clench your teeth?	☐	☐
11. Do you have food catch between your teeth?	☐	☐
12. Have you ever had local anaesthetic (freezing)?	☐	☐
Any complications? ☐ Yes ☐ No Specify _____	☐	☐
13. Have you ever had any problems with previous dental treatments? Specify _____	☐	☐

14. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps
☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gums) ☐ Root Canal

15. Are you satisfied with your teeth? Specify _____	☐	☐

Thank you

Welcome

Patient ID# _____

Medical Alert _____

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

Patient Information

A parent or guardian will be responsible for decisions on my treatment ☐ Yes ☐ No

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: ____/____/____ Home Tel. (____) _____ Work Tel. (____) _____
D M Y

E-Mail: _____

Emergency Contact: _____ Tel. (____) _____

Family Doctor: _____ Tel. (____) _____

Referring Doctor: _____ Tel. (____) _____

Financial Information

Method of payment: Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐

Person responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

IF DIFFERENT FROM ABOVE

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: ____/____/____ Home Tel. (____) _____ Work Tel.(____) _____
D M Y

PRIMARY INSURANCE

Ins. Company: _____ Tel. (____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID#: _____

Max Cov. _____ % coverage for _____Basic _____Maj. Restorative _____Orthodontic

SECONDARY INSURANCE

Ins. Company: _____ Tel. (____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID#: _____

Max Cov. _____ % coverage for _____Basic _____Maj. Restorative _____Orthodontic

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ☐ Self ☐ Parent/Guardian Print name Date