

PATIENT INFORMATION

Name _____ Sex F M

Address _____

City/Prov. _____ Postal Code _____

Home # _____ Business # _____ Cell # _____

Birth Date _____ Employer _____ Occupation _____
mm/dd/yyyy

In case of emergency who should be notified? _____ Relationship _____

Emergency Phone Numbers: _____ Work # _____ Home # _____

Parent/Guardian/Caregiver 1 Information

Name (Surname, Given): _____ Relationship _____

Address _____ Phone # _____

City/Prov. _____ Postal Code _____

Employer _____ Occupation _____ Work # _____

Parent/Guardian/Caregiver 2 Information

Name (Surname, Given): _____ Relationship _____

Address _____ Phone # _____

City/Prov. _____ Postal Code _____

Employer _____ Occupation _____ Work # _____

Person financially responsible for account (if different from patient) _____

Relationship to patient _____ Is patient covered by insurance? Y N

Are you likely to be available on short notice for future appointments or changes? Y N

We would like to send you appointment reminders/confirmations. Would you prefer to be contacted by:

Phone Text Email Text & Email Email _____

We would like to send you communications which may include newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us.

PLEASE COMPLETE THIS SECTION IF YOU ARE COVERED BY INSURANCE

INSURANCE

The following information is necessary for proper insurance coverage:

Subscriber name _____

Subscriber date of birth _____
mm/dd/yyyy

Insurance company _____ Employer _____

Group/Plan # _____ Subscriber ID# _____

PLEASE COMPLETE THIS SECTION IF YOU HAVE MORE THAN 1 INSURANCE COMPANY:

Second subscriber name _____ Date of birth _____
mm/dd/yyyy

Insurance company _____ Employer _____

Group/Plan # _____ Subscriber ID# _____

Physician's name _____ Phone # _____

Date of last visit _____ Have you been hospitalized in the last year? Y N

mm/dd/yyyy

Describe _____

Do you chew or smoke tobacco? Y N

Women: Are you pregnant? Y N Due Date _____ Nursing? Y N

mm/dd/yyyy

Taking birth control? Y N

Are you currently taking any medications, blood thinners, drugs, pills or herbal supplements? Y N

If so please list and describe all below:

	Name of medication, drug or supplement	Condition taken for
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY MEDICATION OR LATEX? Y N

If so please list and describe all below:

	Drug name	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Do you have any other allergies? Y N

Do you carry an epipen? Y N

If yes, please explain: _____

Do you have or have you ever had a pacemaker, a replacement or a repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Y N

If yes, please explain: _____

Have you been advised to take antibiotic pre-medication prior to dental treatment? Y N

If yes, please explain: _____

Do you have a prosthetic or artificial joint? Y N

If yes, please provide details: _____

Do you have any conditions or have undergone therapies that could affect your immune system? Y N
(Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy, steroid therapy)

If yes, please explain: _____

MEDICAL HISTORY

Have you had hepatitis, jaundice, liver disease, or gastrointestinal disorders? Y N

If yes, please explain: _____

Do you have a bleeding problem, bleeding disorder or bruising tendency? Y N

If yes, please explain: _____

Do you have any or have you ever had any of the following (check all that apply):

<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Stomach ulcers	
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Mental disorder	
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Fainting/dizzy spells	<input type="checkbox"/> Alzheimers/Dementia	
<input type="checkbox"/> Chest pain/Angina	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Eating disorder	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Parkinsons disease	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Drug, Alcohol or Cannabis use	
<input type="checkbox"/> Other _____			

Additional comments: _____

PATIENT DENTAL HISTORY

Reason for today's visit: _____

Do you have a dental problem that needs to be addressed as soon as possible? Y N

Have you been visiting the dentist regularly? Y N

Date of last... dental visit _____ mm/dd/yyyy Cleaning _____ mm/dd/yyyy Full mouth x-rays _____ mm/dd/yyyy

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Are your teeth sensitive to... Hot Cold Biting Sweets Sour N/A

Do your gums bleed regularly? Y N

Does your jaw crack, click or pop when opened widely? Y N

Have you noticed any loosening/movement of your teeth? Y N

Have you had periodontal (gum) treatment? Y N

Have you had orthodontic (braces) treatment? Y N

Have you had an unusual reaction to dental freezing? Y N

Do you experience dental anxiety/nervousness during dental visits? Y N

Please list any other information that you feel we should have to provide you with the best possible dental care:

REFERRAL

How did you here about us?

Referral (family, friend or colleague Internet Health Care Professional Emergency/Walk-in

Other _____

TAKE NOTE

OFFICE POLICY

Your appointment time will be reserved for you. If you are unable to keep the appointments, we will require **24 hours notice**, otherwise it may be necessary to charge for the time lost.

