



## Welcome To Our Dental Office

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency.

**PERSONAL INFORMATION**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Day Month Year  
Birthdate  
(D/M/YY) Age

Name Mr/Mrs/Miss/Ms \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Postal Code \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

**Best Method of Contact? (circle)** E-mail \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of person responsible for this account \_\_\_\_\_

Do you have dental insurance? \_\_\_\_\_

Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_

I.D.# \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_**MEDICAL HISTORY**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Have you ever had a serious illness, operation, or been hospitalized?<br>If yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you under the care of a physician now?<br>If yes, explain _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had a medical examination within the last year?<br>If yes, when? _____                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking any medication presently?<br>If yes, list _____                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have or have you ever had any of the following? (circle)                                |                          |                          |
| Rheumatic Fever   |                          |                          |
| Heart Trouble   |                          |                          |
| High Blood Pressure   |                          |                          |
| Heart Murmur  |                          |                          |
| Venereal Disease  |                          |                          |
| Mental or Nervous Disorder  |                          |                          |
| Joint Replacement   |                          |                          |
| Liver Disease (Jaundice, Hepatitis)   |                          |                          |
| Kidney Disease  |                          |                          |
| Diabetes  |                          |                          |
| Epilepsy  |                          |                          |
| Radiation or X-ray Disease  |                          |                          |
| Gastrointestinal Disease  |                          |                          |
| AIDS / HIV+   |                          |                          |
| Thyroid Disease   |                          |                          |
| Lung Disease  |                          |                          |
| Asthma  |                          |                          |
| Blood Disorders   |                          |                          |
| Anemia  |                          |                          |
| Cancer  |                          |                          |
| Sinusitis   |                          |                          |
| Other _____   |                          |                          |
| 6. Do you have any allergies?<br>If yes, list _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you allergic to any medicines or drugs?<br>If yes, list _____                              | <input type="checkbox"/> | <input type="checkbox"/> |

	YES	NO
8. Have you ever had freezing (local anaesthetic) in your mouth? If yes, have you had ill effects from it? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you bleed abnormally?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever fainted? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have any chest pains?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do your ankles ever swell?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you gained or lost excessive weight recently?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever taken cortisone or steroids?	<input type="checkbox"/>	<input type="checkbox"/>
17. Is there any history of family disease? If yes, list conditions: _____	<input type="checkbox"/>	<input type="checkbox"/>
18. Is there anything else that the dentist should know regarding your medical history?	<input type="checkbox"/>	<input type="checkbox"/>
19. To the best of your knowledge, are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you smoke If yes, how many: _____	<input type="checkbox"/>	<input type="checkbox"/>

**WOMEN**

Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, in what stage of pregnancy are you? _____		

**DENTAL HISTORY**

1. Have you had a complete dental examination with a full series of dental X-rays within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
2. What was the date of your last dental visit? _____		
3. What was done? _____		
4. Have you had any extractions? If yes, did you experience prolonged bleeding after? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had any of the following dental treatments? (circle)		
<div style="display: flex; justify-content: space-around;"> <span>Root Canal</span> <span>Orthodontics</span> <span>Full or partial dentures</span> </div> <div style="display: flex; justify-content: space-around;"> <span>Periodontal (gums)</span> <span>Crowns or Caps</span> <span>Bridgework</span> </div>		
6. Are you aware of bad breath or a bad taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a bad experience at the dentist?	<input type="checkbox"/>	<input type="checkbox"/>
8. What is your present dental problem? _____		

**PATIENT CERTIFICATION AND CONSENT**

I, the undersigned, certify that all of the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information. I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures. **To change your appointment we require 2 business days' notice or a \$50 charge will apply.**

Patient (Parent/Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_