CLIENT INFORMATION

Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. ☐ ☐ Adult ☐ Child

Name: (Last) _____ (First) _____ (Initial) _____

Prefer to be called: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Date of Birth: _____(MM) _____(DD) _____(YY) ☐ Male ☐ Female

Employer / School: _____ Occupation: _____

Email ID: _____ Who may we thank for referring you to our office: _____

Are you available on short notice for future appointments? ☐ Yes ☐ No

Family Physician: _____ Phone: _____

In Case of Emergency Notify : _____ Relation: _____ Phone: _____

Person responsible for this account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian Other:_____

Name: (Last)_____ (First)_____ (Initial)_____ Relation: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Primary Insurance

Subscriber: _____

Date of Birth : _____

Relation: ☐ Self ☐ Spouse Other: _____

Insurance Co. : _____

Policy/Plan # : _____ Division/Sect.#: _____

Subscriber I.D. : _____ SIN: _____

Are You Familiar With Your Plan Details? ☐ Yes ☐ No

Secondary Insurance

Subscriber: _____

Date of Birth: _____

Relation: ☐ Self ☐ Spouse Other: _____

Insurance Co. : _____

Policy/Plan # : _____ Division/Sect.#: _____

Subscriber I.D. : _____ SIN: _____

Are You Familiar With Your Plan Details? ☐ Yes ☐ No

MEDICAL HISTORY **ALL INFORMATION IS CONFIDENTIAL**

The following information is required by the dentist to assist in proper diagnosis and treatment.

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? .... ☐ Yes ☐ No
   Please specify:_____
2. Are you presently under the care of a physician? ..... ☐ Yes ☐ No
   If so, please explain:_____
3. Have you had a medical examination in the last year? ..... ☐ Yes ☐ No
4. Do you use any prescription or non-prescription drugs regularly? ..... ☐ Yes ☐ No
   Please specify:_____
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex?.. ☐ Yes ☐ No
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? .... ☐ Yes ☐ No
   Please specify:_____
7. Have you been hospitalized in the last 5 years? ..... ☐ Yes ☐ No
   Please specify: _____
8. Have you ever experienced any unusual reaction to any of the following? (Please circle) local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? ☐ Yes ☐ No
   If so, please explain:_____
9. Have you been warned against taking any drug or medication? ..... ☐ Yes ☐ No
   Please specify:_____
10. Do you bruise easily or bleed abnormally? ..... ☐ Yes ☐ No
11. Have you ever had organ implants or medical implants? ..... ☐ Yes ☐ No
12. Have you ever fainted? ..... ☐ Yes ☐ No
13. Do your ankles swell? ..... ☐ Yes ☐ No
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ☐ Yes ☐ No
15. Do you have frequent headaches? ..... ☐ Yes ☐ No
16. Do you have A.I.D.S. or have you ever tested positive for H.I.V.? ..... ☐ Yes ☐ No
17. Do you have any of the following? Please check any that apply ..... ☐ Yes ☐ No
17. Are you pregnant or any chance of being pregnant? ..... ☐ Yes ☐ No

☐ Heart Murmur or Mitral Valve Prolapse	☐ Malignant Hyperthermia	☐ Liver Disease	☐ Herpes
☐ Stomach/Intestinal Problems/Ulcers	☐ Epilepsy or Seizures	☐ Heart Attack	☐ Cold Sores
☐ Joint Replacement (hip, knees, etc.)	☐ Veneral Disease	☐ Sinus Trouble	☐ Stroke
☐ Mental or Nervous Disorder	☐ Hyper (hypo) Glycemia	☐ Kidney Problems	☐ Jaundice
☐ High/Low Blood Pressure	☐ Thyroid Disease	☐ Diabetes	☐ Emphysema
☐ Lung Disease (i.e. Asthma)	☐ Arthritis or Rheumatism	☐ Tuberculosis	☐ Glaucoma
☐ Drug/Alcohol Dependency	☐ Scarlet or Rheumatic Fever	☐ Hepatitis A,B,C	
☐ Cortisone/Steroid Therapy	☐ Cancer/Chemotherapy	☐ Other:_____	

DENTAL HISTORY

1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other _____

   Are you presently having dental pains? ..... ☐ Yes ☐ No

   Please specify: _____

   Is there any dental problem you would like to solve as soon as possible? ..... ☐ Yes ☐ No

   Please specify: _____

2. How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other _____

   Former Dentist: _____ Last dental visit: _____

   Last Cleaning: _____ Full mouth series of X-rays: _____

3. How often do you brush your teeth? _____ Floss? _____

4. Do your gums bleed easily? ..... ☐ Yes ☐ No

5. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets? ..... ☐ Yes ☐ No

6. Do you feel you have bad breath at times? ..... ☐ Yes ☐ No

7. Have you ever had jaw joint surgery? ..... ☐ Yes ☐ No

8. Do your have pain in your jaw joints or suffer from migraine headaches? ..... ☐ Yes ☐ No

9. Does any part of your mouth hurt when clenched? ..... ☐ Yes ☐ No

10. Does your jaw crack or pop when opened widely? ..... ☐ Yes ☐ No

11. Have you had ☐ Braces ☐ Oral Surgery ☐ Gum Treatment ☐ Root Canal ☐ Yes ☐ No

12. Do you grind or clench your teeth during the day or night? ..... ☐ Yes ☐ No

13. Do you smoke? Number per day? _____ ..... ☐ Yes ☐ No

14. Do you or does any family member have a problem with snoring? ..... ☐ Yes ☐ No

15. Have you ever experienced any growths or sore spots in your mouth? If so, where? .... ☐ Yes ☐ No

16. Previous problems with dental treatment? Specify: _____ ☐ Yes ☐ No

17. Are you satisfied with the appearance of your teeth? ..... ☐ Yes ☐ No
    Please specify: _____

18. Other dental concerns? _____ ☐ Yes ☐ No

Office Policy: Your appointment time will be reserved exclusively for you. Many people depend on you coming as scheduled. If you are unable to keep your appointments, please give us 48 hours notice. Otherwise it may be necessary to bill you for lost time.

Client Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that I am responsible for payment or dental services provided to my dependants and me.

	Date:	
(Signature) ☐ patient ☐ parent ☐ guardian	MM / DD / YY	REVIEWING DENTIST