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

Name Mr/Mrs/Miss/Ms Birthdate (D/M/YY) Age

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? If yes, explain _____	☐	☐
2. Are you under the care of a physician now? If yes, explain _____	☐	☐
3. Have you had a medical examination within the last year? If yes, when? _____	☐	☐
4. Are you taking any medication presently? If yes, list _____	☐	☐

5. Do you have or have you ever had any of the following? (circle)

Rheumatic Fever	Liver Disease (Jaundice, Hepatitis)	Thyroid Disease
Heart Trouble	Kidney Disease	Lung Disease
High Blood Pressure	Diabetes	Asthma
Heart Murmur	Epilepsy	Blood Disorders
Venereal Disease	Radiation or X-ray Disease	Anemia
Mental or Nervous Disorder	Gastrointestinal Disease	Cancer
Joint Replacement	AIDS / HIV+	Sinusitis

Other _____

6. Do you have any allergies? If yes, list _____	☐	☐
7. Are you allergic to any medicines or drugs? If yes, list _____	☐	☐

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

WOMEN

Are you pregnant? 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?	☐	☐
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? _____	☐	☐

5. Have you ever had any of the following dental treatments? (circle)

Root Canal	Orthodontics	Full or partial dentures
Periodontal (gums)	Crowns or Caps	Bridgework

6. Are you aware of bad breath or a bad taste in your mouth?	☐	☐
7. Have you ever had a bad experience at the dentist?	☐	☐

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: _____