1. PERSONAL INFORMATION (Please Print)

Date _____ (D M Y)

Mr. ☐ Mrs. ☐

Name: Ms. ☐ Miss ☐ Dr. ☐ _____ (GIVEN NAME) _____ (FAMILY NAME)

Date of Birth _____ (D M Y) Age _____

Occupation _____ Referred by _____

Address:

Home _____ (NUMBER) _____ (STREET)

_____ (CITY) _____ (POSTAL CODE)

_____ (E-MAIL ADDRESS) _____ (TEL. NO.)

Business _____ (COMPANY NAME) _____ (NUMBER) _____ (STREET)

_____ (CITY) _____ (POSTAL CODE) _____ (TEL. NO.)

Spouse's Business _____ (COMPANY NAME) _____ (NUMBER) _____ (STREET)

_____ (CITY) _____ (POSTAL CODE) _____ (TEL. NO.)

Name of Child's School _____

Dental Insurance Company _____

Group/Policy No. _____ Cert./ ID No. _____

Spouse's Dental Insurance Company _____

Group/Policy No. _____ Cert./ ID No. _____

Spouse's Name _____

S.I.N. of Ins. Holder _____ Marital Status _____

Physician's Name _____ Telephone _____

Physician's Address _____

2. MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment.
All information is confidential. Please check all boxes.

1. Are you presently under the care of a physician? ..... YES ☐ NO ☐
2. Have you ever been hospitalized? ..... YES ☐ NO ☐
   Specify: _____
3. Do you have a heart or circulatory problem of any kind? ..... YES ☐ NO ☐
   Specify: _____
4. Have you ever had rheumatic fever? ..... YES ☐ NO ☐
5. Do you have allergies? ..... YES ☐ NO ☐
   Specify: _____
6. Are you presently taking any kind of medication? _____ YES ☐ NO ☐
   Specify: A) Drug _____ Reason _____
   B) Drug _____ Reason _____
7. Do you have a bleeding problem? ..... YES ☐ NO ☐
8. Are you pregnant? ..... YES ☐ NO ☐
9. Have you ever had a reaction to any kind of medication? ..... YES ☐ NO ☐
   Specify: _____
10. Do you have any allergy to any drug? i.e. penicillin, painkillers, sedatives or freezing ..... YES ☐ NO ☐
11. Do you presently or have you ever had:

Aids ☐	Hay Fever ☐	Migraine headaches ☐
Anemia ☐	Hemorrhage ☐	Rheumatism ☐
Arthritis ☐	High (low) blood pressure ☐	Scarlet Fever ☐
Asthma ☐	Hyper (Hypo) glycemia ☐	Stomach (Intestinal) ulcer ☐
Blood disorder ☐	Kidney Disease ☐	Stroke ☐
Cancer ☐	Liver disease (e.g.) Hepatitis) ☐	Thyroid problem ☐
Diabetes ☐	Lung Disease ☐	Tuberculosis ☐
Epilepsy ☐	Mental or nervous disease ☐	Venereal disease ☐

12. Have you ever fainted? ..... YES ☐ NO ☐
13. Have you ever had any illness not included above? YES ☐ NO ☐
    Specify _____
14. Are you in good health? ..... YES ☐ NO ☐
    Medical update _____

3. DENTAL HISTORY

1. How frequently do you see your dentist?
   6 months ☐ Yearly ☐ Other _____ Last dental visit _____
2. Have you ever been given oral hygiene instruction in
   Brushing ☐ Flossing ☐ Other _____
3. Have you ever had local anaesthetic? ..... YES ☐ NO ☐
   Any complications? _____ YES ☐ NO ☐
4. Are any of your teeth sensitive to
   Cold ☐ Heat ☐ Sweets ☐ Other _____
5. Do your gums bleed when: Brushing ☐ Flossing ☐ Spontaneously ☐
6. Do your gums feel swollen or tender? ..... YES ☐ NO ☐
7. Does food catch between your teeth when eating? ..... YES ☐ NO ☐
8. Are you aware of any loose teeth? ..... YES ☐ NO ☐
9. Have you ever had a full series of dental x-rays? ..... YES ☐ NO ☐
10. Do you object to our staff taking necessary dental x-rays? ..... YES ☐ NO ☐
11. Does your jaw crack, pop or grate when you open widely? ..... YES ☐ NO ☐
12. Do you grind or clench your teeth? ..... YES ☐ NO ☐
13. Are you tense during dental visits? ..... YES ☐ NO ☐
14. Are you interested in a method to calm you nerves? ..... YES ☐ NO ☐
15. Do you have any habits such as clenching or grinding your teeth, nailbiting or others? ..... YES ☐ NO ☐
    Dental Update _____

PATIENT/GUARDIAN CERTIFICATION, APPROVAL AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information and consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic sedation, x-rays, as indicated, and I will assume responsibility for fees associated with these procedures.
I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.

Patient (Parent, Guardian) Signature _____ Date _____