1 PERSONAL INFORMATION (Please Print)

DATE ___/___/___ (D M Y)

Name: Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr. ☐ ______________ (FIRST NAME) (LAST NAME)

Address: ______________ (NUMBER) (STREET) (APT)

______________ (CITY) (PROV) (POSTAL CODE) Place of Birth ______________

Date of Birth ___/___/___ (D M Y) Height ______________ Weight ______________

Telephone: Residence ______________ Business ______________ Ext. ______________

Email ______________ Referred by: ______________

Occupation: ______________ Place of Business: ______________

Primary Dental Insurance Company: ______________

Group No. ______________ ID No. ______________

Secondary Dental Insurance Company: ______________

Group No. ______________ ID No. ______________

Secondary Policy Holder: ______________ Date of Birth: ___/___/___ (D M Y)

Physician: Name & address: ______________ Telephone ______________

In case of emergency please notify: Name ______________

Relationship ______________ Telephone ______________

2. MEDICAL HISTORY

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

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 any allergies? .... YES ☐ NO ☐
   Specify: ______________
6. Are you presently taking any kind of medication? .... YES ☐ NO ☐
   Specify: A) Drug ______________ Reason ______________
   B) Drug ______________ Reason ______________
   C) Drug ______________ Reason ______________
7. Do you have or have you ever had 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 presently or have you ever had:

Anaemia ☐	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 disorder ☐	Venereal disease ☐
Hay Fever ☐	Migraine headaches ☐	HIV ☐

11. Have you ever had a concussion? .... YES ☐ NO ☐
12. Have you ever fainted? .... YES ☐ NO ☐
13. Have you ever had any illness not included above? .... YES ☐ NO ☐
    Specify: ______________

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 ______________
4. Are any of your teeth sensitive to:
   Cold ☐ Sweets ☐ Heat ☐ Other ______________
5. Do your gums bleed when: Brushing ☐ Flossing ☐ Spontaneously ☐
6. Do your gums feel swollen or tender? .... YES ☐ NO ☐
7. Do you catch food between your teeth? .... YES ☐ NO ☐
8. Are you aware of any loose teeth? .... YES ☐ NO ☐
9. Have you ever had a full mouth series of dental x-rays? .... YES ☐ NO ☐
10. Does your jaw crack, pop or grate when you open widely? .... YES ☐ NO ☐
11. Do you grind or clench your teeth? .... YES ☐ NO ☐
    Dental Update: ______________

PATIENT CERTIFICATION AND APPROVAL

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.

Patient (Parent, Guardian) Signature ______________ Date ______________

PATIENT (GUARDIAN) CONSENT (FOR MINORS)

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.

Patient (Parent, Guardian) Signature ______________ Date ______________