Today's date: _____

Patient Information (all information is strictly confidential and will remain with this office.)

Name: _____
Last First Prefer to be called

Address: _____
Street City Prov Postal Code

Telephone: _____
Home Work Cell

Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Month / day / year

Employed by: _____ Occupation: _____

How did you hear about our office? _____

Whom may we thank for referring you? _____ Telephone: _____

Medical Information

Medical doctor: _____ Telephone: _____
Date of last physical exam: _____ Do you consider yourself to be in good health: _____
Are you presently under the care of a medical doctor: _____ If yes please specify _____
Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins:
_____
Do you have any allergies or have you had any reaction to (medications, anesthetics, metals, latex, antibiotics, pain killers, dairy, etc.): _____
Do you have to take antibiotics prior to dental work? If yes, why? _____
Have you had heart surgery? If yes, please specify: _____
Do you have any artificial prosthesis (Joints, heart valve, etc)? If yes please specify: _____
Do you have abnormal bleeding? _____ Do you become breathless easily? _____

Do you have or have had any of the following:

High blood pressure ___ Yes ___ No	Tuberculosis ___ Yes ___ No	Hepatitis type ___ Yes ___ No	**Hiv/aids** ___ Yes ___ No
Amenia ___ Yes ___ No	Headaches ___ Yes ___ No	Chest Pain ___ Yes ___ No	**Tested** ___ Yes ___ No
Sinus problems ___ Yes ___ No	Herpes ___ Yes ___ No	Blood disorders ___ Yes ___ No	Digestive disorders ___ Yes ___ No
Low blood pressure ___ Yes ___ No	Glaucoma ___ Yes ___ No	Liver disease ___ Yes ___ No	Thyroid disease ___ Yes ___ No
Head Or Neck injuries ___ Yes ___ No	Diabetes ___ Yes ___ No	Asthma ___ Yes ___ No	Arthritis ___ Yes ___ No
Venereal Disease ___ Yes ___ No	Cancer ___ Yes ___ No	Rheumatic Fever ___ Yes ___ No	Radiation Therapy ___ Yes ___ No
Nervous Problems ___ Yes ___ No	Heart Trouble ___ Yes ___ No	Heart Murmur ___ Yes ___ No	Chemotherapy ___ Yes ___ No
Epilepsy ___ Yes ___ No	Kidney Trouble ___ Yes ___ No	Emphysema ___ Yes ___ No	Antidepressants ___ Yes ___ No
Alcohol/drug Dependency ___ Yes ___ No	Ulcer ___ Yes ___ No	Psychiatric care ___ Yes ___ No	Stroke ___ Yes ___ No

Others: _____
Do you smoke? _____ If so how much? _____ Do you take recreational drugs? _____
Women: Are you taking Birth Control Pills? _____ Are you pregnant? _____

This is to certify that I, the undersigned, consent to the performing or the procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.
Signed: _____

Account Information

Person financially responsible for the account: _____

IF THE PATIENT IS UNDER 18 YEARS OF AGE

Father's Name: _____
Father's address (if different than child): _____
Father's telephone: Home _____ Work _____ Cell _____

Mother's Name: _____
Mother's address (if different than child): _____
Mother's telephone: Home _____ Work _____ Cell _____

In case of Emergency, please notify

Name: _____ Relationship: _____
Telephone: Home _____ Work _____ Cell _____
Address:_____
_____

Dental History

Are you having any discomfort at this time? If yes please specify: _____
_____
Have you been under the regular care of a dentist? _____
How long since your last dental visit? _____
What was done at that time? _____
Do your gums feel tender or swollen? _____
Is there often bleeding when you floss? _____
Have you ever been given local anesthetic (freezing)? _____
Have you ever had general anesthetic? _____
Are you aware of any lump or swelling in your mouth? _____
Are you satisfied with the appearance of your teeth? _____
Are you anxious to keep your natural teeth? _____
Are you tense during your dental visits? _____

Are you interested in a method to calm your nerves? _____
Do you have an unpleasant taste or odor in your mouth? _____
Describe what you would like done with your teeth: _____
_____
_____

Do you currently experience any of the following?

Loose teeth _____ Yes _____ No	Ear ache _____ Yes _____ No	Spaced or crooked teeth _____ Yes _____ No
Bad Breath _____ Yes _____ No	Gagging _____ Yes _____ No	Unexplained noose bleed _____ Yes _____ No
Missing Teeth _____ Yes _____ No	Sore Gums _____ Yes _____ No	Popping or clicking of the jaw _____ Yes _____ No
Bleeding gums _____ Yes _____ No	Headache _____ Yes _____ No	Unsatisfactory Dentures _____ Yes _____ No
Neck Pain _____ Yes _____ No		

Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep your appointment we require 48 hours notice, otherwise, it may be necessary to charge for the time lost.

I understand that I am ultimately responsible for the total fees associated with the treatment performed.

Date: _____ **Patient/ Guardian signature: _____**