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 you had any of the following:

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Hepatitis Type	☐	☐	Hiv/Aids	☐	☐
Anemia	☐	☐	Headaches	☐	☐	Chest Pain	☐	☐	Tested	☐	☐
Sinus Problems	☐	☐	Herpes	☐	☐	Blood Disorders	☐	☐	Digestive Disorders	☐	☐
Low Blood Pressure	☐	☐	Thyroid Problems	☐	☐	Liver Disease	☐	☐	Glaucoma	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Asthma	☐	☐	Head Or Neck Injuries	☐	☐
Cancer	☐	☐	Venereal Disease	☐	☐	Rheumatic Fever	☐	☐	Radiation Therapy	☐	☐
Nervous Problems	☐	☐	Heart Trouble	☐	☐	Heart Murmur	☐	☐	Chemotherapy	☐	☐
Epilepsy	☐	☐	Kidney Trouble	☐	☐	Emphysema	☐	☐	Antidepressants	☐	☐
Psychiatric Care	☐	☐	Stroke	☐	☐	Ulcer	☐	☐	Alcohol/Drug Dependency	☐	☐

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 of the dental 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 ____________

Who is financially responsible for the account? ______________________________

Insurance Information

1st INSURANCE

Name of Insurance: ____________ Policy# ____________ Id# ____________
Name of Policy Holder: ____________ Date of Birth: ____________ (M / D / Y) Employer: ____________
Basic Services: ________ % Maximum: ________ $ Major Services: ________ % Maximum: ________ %
Recall frequency: ________ mths Scaling: ________ units Year is: ____________

2nd INSURANCE

Name of Insurance: ____________ Policy# ____________ Id# ____________
Name of Insured: ____________ Date of Birth: ____________ (M / D / Y) Employer: ____________
Basic Services: ________ % Maximum: ________ $ Major Services: ________ % Maximum: ________ %
Recall frequency: ________ mths Scaling: ________ units Year is: ____________

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 dental visits? ______________________

Are you interested in a method to calm your nerves? ______________________

Do you have an unpleasant taste or odor in you mouth? ______________________

Describe what you would like done with your teeth: ______________________

____

____

Do you currently experience any of the following:

Loose teeth	YES ☐	NO ☐	Bleeding gums	YES ☐	NO ☐
Ear ache	YES ☐	NO ☐	Headache	YES ☐	NO ☐
Spaced or crooked teeth	YES ☐	NO ☐	Bleeding gums	YES ☐	NO ☐
Bad breath	YES ☐	NO ☐	Neck pain	YES ☐	NO ☐
Unexplained nosebleed	YES ☐	NO ☐	Unsatisfactory dentures	YES ☐	NO ☐
Popping or clicking in the jaw joints	YES ☐	NO ☐	Sore gums	YES ☐	NO ☐
Missing teeth	YES ☐	NO ☐	Gagging	YES ☐	NO ☐

Office Policy

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

It is likely that there will be a difference in fees paid by my insurance company and charged by my dentist. I understand that I am ultimately responsible for the total fees associated with the treatment performed. Including the fees not covered by my insurance.

Date: ______________ Patient/Guardian Signature: ______________________