NAME .....

NAME (PREFERRED) ..... DATE OF BIRTH ..... D M Y

ADDRESS ..... PHONE NO. .....

CITY ..... POSTAL CODE .....

OCCUPATION (SELF) ..... OCCUPATION (SPOUSE) .....

EMPLOYER (SELF) ..... EMPLOYER (SPOUSE) .....

OFFICE PHONE ..... OFFICE PHONE .....

CELL PHONE: ..... BEST CONTACT #: .....

EMAIL ADDRESS: .....

WHOM MAY WE THANK FOR RECOMMENDING YOU TO OUR OFFICE? .....

DENTAL HISTORY

1. What is the main reason for your visit: regular dental checkup ☐
   other .....
2. Date of last dental visit .....
3. Name of former dentist ..... City .....
4. Do your gums bleed when you brush your teeth? ..... NO YES
5. Are any of your teeth sensitive to hot, cold, sweets, pressure? ..... NO YES
6. Does food get caught between any of your teeth? ..... NO YES
7. Are you satisfied with the appearance of your teeth? ..... NO YES
8. Have you had any trouble with local or general anaesthesia in the past? ..... NO YES
9. Are you aware of grinding or clenching your teeth? ..... NO YES
10. Do you notice any clicking or cracking of your jaws? ..... NO YES
11. Do you ever have a sore or stiff jaw in the morning? ..... NO YES

HEALTH HISTORY

(All information is confidential)

1. Name of Physician ..... Address/Clinic .....
2. Are you taking any medicine or pills at the present time? ..... NO YES
   Please list .....
3. Are you sensitive or allergic to any drugs or medicines? ..... NO YES
   What? .....
4. Has a doctor told you that you have heart trouble or heart disease? ..... NO YES
5. Do you suffer from stomach or bladder trouble? ..... NO YES
6. Has a doctor said you have kidney or liver trouble? ..... NO YES
7. Have you ever had hepatitis or jaundice? ..... NO YES
8. Have you had abnormal bleeding after a cut or extraction? ..... NO YES
9. For women only - Are you pregnant? ..... NO YES
10. Have you ever had any of the following (Please circle)

Asthma	Fractured jaw	Epilepsy
Rheumatic fever	Addison's disease	Allergies
Scarlet fever	High blood pressure	Thyroid disease
Pneumonia	Anaemia (thin blood)	Glaucoma
Tuberculosis	Diabetes	

11. Do you have any conditions which would affect your immune system? ..... NO YES
    (ie. Hodgkins disease, AIDS, Steroid therapy)
12. Any other medical condition not listed above? .....

CONSENT

This is to certify that I, undersigned, consent to the performing of dental and oral surgery procedures, including the use of local anesthesia as indicated. I understand treatment proposed may not be covered by or may exceed my dental plan benefits and I am financially responsible for costs of treatment. I consent to the collection, use, retention and disclosure of personal information as is required for my dental care, as outlined in the office Personal Information Policy. I hereby authorize the release of information contained in claims to be submitted electronically to my insuring company plans administrator, and authorize direct payments to the dentist providing treatment.

Patient's (Guardian's) Signature ..... Date .....