Name _____

Address _____

City _____ Prov. _____ Postal Code _____

Res. Phone _____ Bus. Phone _____

MEDICAL ALERT

ID # _____ Date of Birth D _____ M _____ Y _____

Occupation _____ Employer _____

EMail Address _____ Previous Dentist _____

Physician _____ Phys. Phone# _____

Why have you decided to change dental offices? _____

In case of emergency call _____ Tel. _____

INSURANCE INFORMATION

Name of insured (if different from above) _____

Insurance Company _____ Birthdate of Insured D _____ M _____ Y _____

Division (if applicable) _____ Policy/Group _____

Employer _____ Certificate ID# _____

Do you have secondary insurance? _____

MEDICAL HISTORY

The following information is required for medical and legal reasons, and is strictly confidential. All facts are needed for correct diagnosis and safe treatment.

	YES	NO
1. Is your physician treating you now? Specify _____	☐	☐
2. Are you taking any medication or tablets? Please list them.....	☐	☐
_____ _____ _____ _____		
3. Have you had an unusual reaction to any drugs or medicines? Please list...	☐	☐
_____ _____ _____ _____		
4. Have you taken cortisone or steroids?	☐	☐
5. Do you have any allergies (hayfever, Latex)? _____	☐	☐
6. Do you have any sinus problems?	☐	☐
7. Do you bleed or bruise easily?	☐	☐
8. Do you have a pacemaker or Mital Valve Prolapse?	☐	☐
9. Do you have heart disease or a heart murmur?	☐	☐
10. WOMEN: Are you pregnant?	☐	☐
11. Do you smoke? If so, how much? _____	☐	☐
12. Did you have any artificial joint surgery?	☐	☐

13. Do you have or have you ever had any of the following? Please ✔

☐ Anemia	☐ Chronic Lung Disease	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Asthma	☐ Diabetes	☐ Kidney Trouble	☐ Stroke
☐ Blood Disorders	☐ Epilepsy	☐ Leukemia	☐ Thyroid Trouble
☐ Cancer	☐ Heart Attack	☐ Liver Trouble	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Trouble	☐ Radiation	☐ Venereal Disease
☐ Eating Disorders (anorexia nervosa, bulimia etc.)		☐ Psychiatric disorders/treatment	☐ AIDS / HIV

DENTAL HISTORY

	YES	NO
14. Does food catch between your teeth?	☐	☐
15. Do your gums bleed when brushing or eating?	☐	☐
16. Have you ever experienced any of the following jaw problems? Please ✔		
☐ Popping / clicking in your jaw joints?		
☐ Pain in your jaw joints, around ear or on side of face?		
☐ Difficulty in opening or closing?		
☐ Pain when teeth are clenched?		
☐ Pain or difficulty when chewing?		
17. Are you happy with the appearance of your teeth?	☐	☐
18. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment? ..... Specify _____	☐	☐
19. Do you have any specific requests that would make your visit more pleasant? Specify? _____	☐	☐
20. Date of your last dental visit: _____		
Date of your last dental cleaning: _____		
Date of your last complete set of x-rays: _____		
21. Any other conditions or problems of which your dentist should be aware? Specify _____	☐	☐

I authorize release, to my insuring company/plan administrator, the information contained in claims submitted electronically. I authorize the use of my study models, photographs and/or x-rays for the purpose of lecturing and publication. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

This is to certify that I, the undersigned, understand that the above information is mandatory for my proper and safe care and that this information is correct and complete to the best of my knowledge. I hereby give permission to contact any third party to verify and expand on information given.

Method of Payment ☐ VISA ☐ Mastercard ☐ AMEX ☐ Cash ☐ Interac

Signature of Patient / Parent / Guardian _____ Date _____

Reviewed by treating Dentist _____ Date _____