Confidential Patient Record

Patient: Mr. / Mrs. / Miss_____
Surname First Middle

Date of Birth: _____ Emergency Contact Name: _____ Phone #:_____
Day Month Year

Address:_____ Marital Status: ☐ Married ☐ Single ☐ Common Law

City/Prov: _____ Postal Code: _____ **Email:** _____

Home #: _____ Work #: _____ Cell #: _____

How did you hear about us? Postcard Internet Search Walk By (big sign) Newsletter
(please circle) Website Friend/Family Referral (name) _____
Other (please specify) _____

DENTAL INSURANCE INFORMATION

Insurance Company #1: _____ Insurance Company #2: _____
Policy/Group #: _____ Policy/Group #: _____
iD #: _____ ID #: _____
Policy Holder's Name: _____ Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's Birth Date: _____
Policy Holder's Employer: _____ Policy Holder's Employer _____
Patient's Relationship to Subscriber : ☐ Self ☐ Spouse ☐ Child ☐ Other_____

MEDICAL HISTORY

1. Are you currently in good health? ☐ Yes ☐ No
   If no, please explain _____
2. Are you currently taking any medications or vitamins (prescription, over-the-counter, recreational)? ☐ Yes ☐ No
   If yes, please list_____
3. Do you currently smoke? ☐ Yes ☐ No
4. Are you allergic to or ever had a reaction to any of the following: **(please circle)**
   Penicillin Local Anesthetic (Freezing) Sulfa Drugs Erythromycin
   Codeine Aspirin (ASA) Latex Other _____
5. Are you currently (or within the past 2 years) being treated for any medical condition ☐ Yes ☐ No
   If Yes, Please explain _____
6. Do you bleed more or longer than normal after a cut, bruise, surgery or previous tooth removal? ☐Yes ☐No
7. Have you ever had a serious illness or operation? ☐ Yes ☐ No
8. Do you currently have or ever had any of the following conditions? **(please circle)**

Heart Trouble or stroke	Heart Murmur	Thyroid Disorder	Rheumatic Fever
Breathing Problems	Blood Disorders	HIV + / AIDS	Tumors or Cancer
High / Low Blood pressure	Hepatitis ☐ A ☐ B ☐ C	Artificial Joints	Liver /Kidney Disease
Depression	Diabetes (Type I/II)	Tuberculosis	Epilepsy or Seizure
Anxiety	Asthma	Hormonal Disorder Other: _____	

9 Women: Are you Pregnant? ☐ Yes ☐ No If yes, which trimester? _____
10. Is there anything else we should know about your health? ☐ Yes ☐ No If so, please explain_____

DENTAL HISTORY

1. What dental condition(s) concern you at present? _____
2. When was your last dental check-up and cleaning? _____
3. Were X-rays taken at your last dental visit? ☐ Yes ☐ No
4. Have you noticed any signs of the following? **(please circle)**
   Bleeding gums Swelling of Gums Gum Ache Receding Gums Loose Teeth Drifting of Teeth
5. Do you have any clicking, popping or pain in your jaw joint? ☐ Yes ☐ No
6. Are you aware of clenching or grinding your teeth? ☐Yes ☐ No
7. Do you have any missing teeth that you feel should be replaced? ☐ Yes ☐ No
8. Would you like to improve the appearance of your teeth? ☐ Yes ☐ No
9. Do you floss your teeth? ☐ Yes ☐ No
10. Have you had any complications or difficulty with previous dental treatment? ☐ Yes ☐ No
11. How do you rate yourself as a dental patient? ☐ Calm ☐ Lightly Nervous ☐ Very Anxious

I hereby certify that the Medical and Dental Histories provided are accurate and complete to the best of my knowledge. I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic or any drugs as indicated and I will assume responsibility for fees associated with those procedures.

Date_____ Signature _____