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? **(please circle)** Postcard Internet Search Walk By (big sign) Newsletter 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 ______________________