

**Patient Information:**

Last name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal Code\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: (d/m/y) \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Gender: \_\_ M \_\_ F Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone HOME: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUSINESS: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you wish to receive reminders by \_\_\_\_email ? \_\_\_\_ text?

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of Emergency, notify: name, phone, relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is legally responsible for payment of this account?

\_\_\_Self \_\_\_\_ Other person: name, relationship, phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Information:**

Purpose of today’s visit: \_\_\_check-up (exam) \_\_\_cleaning \_\_\_specific problem \_\_\_toothache \_\_\_other

Previous Dentist Name and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate date of last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you go to the dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have, or have you ever had, any of the following? Please check off all that apply:

* teeth sensitive to cold
* teeth sensitive to sweet
* gums bleed when brush / floss
* bad breath
* dry mouth
* clench or grind teeth
* jaw clicks, pops or locks
* frequent headaches
* canker sores / cold sores
* food caught between teeth
* loose teeth
* chipped teeth
* had wisdom teeth removed
* had orthodontics (braces)
* had periodontal (gum) surgery

How nervous are you about dental treatment? Indicate by circling on the scale below:

*NOT AT ALL* – 1 – 2 – 3 – 4 – 5 – *VERY ANXIOUS*

If nervous, are you interested in additional techniques, along with “freezing” to help you? \_\_\_Y \_\_\_N \_\_\_ maybe

Have you had any problems or complications with previous dental treatment? \_\_\_Y \_\_\_N \_\_\_ maybe

Do you have interest in wanting to change the appearance of your teeth or smile? \_\_\_Y \_\_\_N \_\_\_ maybe

**Medical Information:**

Physician’s name, address, phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Do you have or have you ever had any of the following? Please check off all that apply:*

* High Blood pressure
* Low Blood pressure
* Cholesterol high
* Angina
* Heart attack
* Stroke
* Heart surgery
* Artificial heart valve
* Heart infection (endocarditis)
* Heart transplant
* Congenital heart defect (birth)
* Heart murmur
* Mitral valve problems
* Pacemaker
* Other heart problem

*Do you have, or have you ever had, any of the following? Please check off all that apply:*

* Artificial joint (knee, hip, other)
* Arthritis
* Osteoporosis
* Back / neck issue
* Autoimmune issue
* Cancer
* AIDS / HIV infection
* Hepatitis
* Liver disease
* Bleeding disorder
* Asthma
* Lung disease
* Tuberculosis
* Steroid therapy
* Diabetes
* Kidney disease
* Thyroid condition
* Digestive problems
* Stomach ulcers
* GERD / acid reflux
* Epilepsy or seizures
* Mental health issue
* Skin condition
* Vertigo / balance
* Hearing problem
* Sleep apnea
* Prone to fainting

Are there any OTHER conditions or diseases that you have or have been treated for:

If YES, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***yes no ?***

Are you taking ANY medications or non-prescription drugs of any kind?

If YES, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any environmental allergies? (eg. hayfever, foods, latex / rubber, metals, acrylic)

If YES, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an allergy or adverse reaction to any medicine or injections?

(eg. Penicillin, aspirin, local anaesthetics “dental freezing”, codeine, sulpha)

If YES, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for any illnesses or operations?

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any disease or medical problems that run in your family?

(eg. diabetes, cancer, heart disease)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or did you smoke tobacco (or vape)? If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages on a regular basis? If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? (eg. marijuana, cocaine) If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you identify as a patient with a disability? If so, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For women only: are you pregnant? If yes, due date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that the information given above is true to the best of my knowledge. Should there be any change to my present health status in the future, I will advise the attending dentist / hygienist.

Where my physician may need to be contacted, I consent to my physician providing any information with regards to details in my medical history which may help ensure a safe dental treatment. I understand that treatment may be delayed until all medical information required is received.

This is to certify that I, the undersigned, consent to the performing of dental procedures agreed to be necessary or advisable including the use of local anaesthetic and / or relative analgesia as indicated and I will assume responsibility for fees associated with those procedures. I also consent to sharing my information and discussion with dental specialists as required for my overall dental health and treatment plan.

I understand the appointment policy where my appointment time will be reserved time specifically for me and if unable to keep my appointment, the office requires 48 hours notice otherwise it may be necessary to charge for time lost.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_