Today's Date ____________________

Patient Information (All information is strictly confidential and will remain with this office.)

Name: ____
Last | First | Prefer to be called

Address: ____
Street | City | Prov | Postal Code

Telephone: ____
Home | Work | Cell

Email: ____

Date of Birth: ____________ (Month / Day / Year) Age: ________ Sex: ____________ Marital Status: ____________

Employed by: ____________________ Occupation: ____________________

How did you hear about our office? ____________________

Whom may we thank for referring you? ____________________ Telephone: ____________

Medical Information

Medical Doctor: ____________________ Telephone: ____________

Date of last physical exam: ____________ Do you consider yourself to be in good health? ____________

Are you presently under the care of a medical doctor: ________ If yes please specify: ____________

Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins:

____

Do you have any allergies or have you had any reaction to (medications, anesthetics, metals, latex, antibiotics, pain killers, dairy, etc.):

____

Do you have to take antibiotics prior to dental work? If yes, why? ____________

Have you had heart surgery? If yes, please specify: ____________

Do you have any artificial prosthesis (Joints, heart valve, etc)? If yes please specify: ____________

Do you have abnormal bleeding? ____________ Do you become breathless easily? ____________

Do you have or have you had any of the following:

Condition			Condition			Condition			Condition		
High Blood Pressure	YES ☐	NO ☐	Tuberculosis	YES ☐	NO ☐	Hepatitis Type	YES ☐	NO ☐	Hiv/Aids	YES ☐	NO ☐
Anemia	YES ☐	NO ☐	Headaches	YES ☐	NO ☐	Chest Pain	YES ☐	NO ☐	Tested	YES ☐	NO ☐
Sinus Problems	YES ☐	NO ☐	Herpes	YES ☐	NO ☐	Blood Disorders	YES ☐	NO ☐	Digestive Disorders	YES ☐	NO ☐
Low Blood Pressure	YES ☐	NO ☐	Thyroid Problems	YES ☐	NO ☐	Liver Disease	YES ☐	NO ☐	Glaucoma	YES ☐	NO ☐
Arthritis	YES ☐	NO ☐	Diabetes	YES ☐	NO ☐	Asthma	YES ☐	NO ☐	Head Or Neck Injuries	YES ☐	NO ☐
Cancer	YES ☐	NO ☐	Venereal Disease	YES ☐	NO ☐	Rheumatic Fever	YES ☐	NO ☐	Radiation Therapy	YES ☐	NO ☐
Nervous Problems	YES ☐	NO ☐	Heart Trouble	YES ☐	NO ☐	Heart Murmur	YES ☐	NO ☐	Chemotherapy	YES ☐	NO ☐
Epilepsy	YES ☐	NO ☐	Kidney Trouble	YES ☐	NO ☐	Emphysema	YES ☐	NO ☐	Antidepressants	YES ☐	NO ☐
Psychiatric Care	YES ☐	NO ☐	Stroke	YES ☐	NO ☐	Ulcer	YES ☐	NO ☐	Alcohol/Drug Dependency	YES ☐	NO ☐

Others: ____

Do you smoke? ________ If so how much? ____________ Do you take recreational drugs? ____________

Women: Are you taking Birth Control Pills? ________ Are you pregnant? ____________

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.

Signed: ____________________

Account Information

Person financially responsible for the account: ______________________________

IF THE PATIENT IS UNDER 18 YEARS OF AGE

Father's Name: ______________________________
Father's address (if different than child): ______________________________
Father's telephone: Home ______________ Work ______________ Cell ______________

Mother's Name: ______________________________
Mother's address (if different than child): ______________________________
Mother's telephone: Home ______________ Work ______________ Cell ______________

Who is financially responsible for the account? ______________________________

Insurance Information

1st INSURANCE

Name of Insurance: ______________ Policy# ______________ Id# ______________
Name of Policy Holder: ______________ Date of Birth: ______________ (M / D / Y) Employer: ______________
Basic Services: ________ % Maximum: ________ $ Major Services: ________ % Maximum: ________ %
Recall frequency: ________ mths Scaling: ________ units Year is: ______________

2nd INSURANCE

Name of Insurance: ______________ Policy# ______________ Id# ______________
Name of Insured: ______________ Date of Birth: ______________ (M / D / Y) Employer: ______________
Basic Services: ________ % Maximum: ________ $ Major Services: ________ % Maximum: ________ %
Recall frequency: ________ mths Scaling: ________ units Year is: ______________

In Case of Emergency please notify

Name: ______________________________ Relationship: ______________
Telephone: Home ______________ Work ______________ Cell ______________
Address: ______________________________

Dental History

Are you having any discomfort at this time? If yes please specify: ______________________

____

Have you been under the regular care of a dentist? ______________________

How long since your last dental visit? ______________________

What was done at that time? ______________________

Do your gums feel tender or swollen? ______________________

Is there often bleeding when you floss? ______________________

Have you ever been given local anesthetic (freezing)? ______________________

Have you ever had general anesthetic? ______________________

Are you aware of any lump or swelling in your mouth? ______________________

Are you satisfied with the appearance of your teeth? ______________________

Are you anxious to keep your natural teeth? ______________________

Are you tense during dental visits? ______________________

Are you interested in a method to calm your nerves? ______________________

Do you have an unpleasant taste or odor in you mouth? ______________________

Describe what you would like done with your teeth: ______________________

____

____

Do you currently experience any of the following:

Loose teeth	YES ☐	NO ☐	Bleeding gums	YES ☐	NO ☐
Ear ache	YES ☐	NO ☐	Headache	YES ☐	NO ☐
Spaced or crooked teeth	YES ☐	NO ☐	Bleeding gums	YES ☐	NO ☐
Bad breath	YES ☐	NO ☐	Neck pain	YES ☐	NO ☐
Unexplained nosebleed	YES ☐	NO ☐	Unsatisfactory dentures	YES ☐	NO ☐
Popping or clicking in the jaw joints	YES ☐	NO ☐	Sore gums	YES ☐	NO ☐
Missing teeth	YES ☐	NO ☐	Gagging	YES ☐	NO ☐

Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we require 48 hours' notice, otherwise, it may be necessary to charge for the time lost.

It is likely that there will be a difference in fees paid by my insurance company and charged by my dentist. I understand that I am ultimately responsible for the total fees associated with the treatment performed. Including the fees not covered by my insurance.

Date: ______________ Patient/Guardian Signature: ______________________

Financial Information

All accounts payable when services are rendered. Interest charged on overdue accounts.

Preferred method of payment:

INTERAC ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ CASH ☐ CARE CREDIT ☐ WE DO NOT ACCEPT CHEQUES

Driver's license ______________________ Credit card ____________________________ Exp. ___ /_____

Date: ____________________ Patient/Guardian Signature: ____________________________________