PATIENT INFORMATION

Date: _____

Your co-operation in filling out the data on this questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

Name: Dr. / Mrs. / Mr. / Ms. _____
Last First Middle

Age: _____ Sex: _____ Marital Status: _____

Address: _____
Street City Prov. Postal Code

Home Phone: _____ Bus. Phone: _____

Date of Birth: _____ Email Address _____

Occupation: _____

Employed by: _____

Dental Insurance: Yes ❑ No ❑ Name of Company _____ ID# _____ Policy# _____

Family Physician: _____ Phone No.: _____

Dentist: _____

Whom may we thank for referring you? _____

In case of Emergency notify: Name: _____

Address: _____

Relationship: _____ Phone No.: _____

OFFICE POLICY

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

Office policy is that services are paid for at each visit as they are performed. However in certain circumstances arrangements for payment may be made by consulting with the doctor.

CONFIDENTIAL MEDICAL HISTORY

	Yes	No
1. Date of last physical examination _____		
2. Are you presently under the care of a physician?	☐	☐
3. Are you presently taking any pills, drugs or medication? Please specify _____		
4. Have you taken any prolonged medication in the past? Prescription or Non-Prescription?	☐	☐
Please Specify _____		
5. Have you had rheumatic fever?	☐	☐
6. Do you have heart disease or a murmur?	☐	☐
7. Do you become breathless easily?	☐	☐
8. Have you had abnormal bleeding?	☐	☐
9. Have you taken cortisone or steroids?	☐	☐
10. Have you any allergies?	☐	☐
11. Have you any allergies to any drugs or medicines?	☐	☐

	Yes	No
12. Are you a smoker?	☐	☐
13. Have you ever been hospitalized and was surgery performed?	☐	☐
14. Are your ankles often swollen?	☐	☐
15. Have you gained or lost excessive weight recently?	☐	☐
16. Do any members of your family have diabetes?	☐	☐
17. Have you ever had radiation or x-ray therapy?	☐	☐

18. Do you have or have you had? (Please circle)

High Blood Pressure	Arthritis	Cancer	Stroke
Low Blood Pressure	Epilepsy	Tuberculosis	Psychiatric Care
Nervous Problems	Diabetes	Ulcer	Venereal Disease
Thyroid Problems	Liver Trouble	Asthma	Fainting Spells
Heart Trouble	Hepatitis	Scarlet Fever	
Kidney Trouble	Chest Pain	Blood Disorders	
Anemia	Herpes	Sinus Problems	

19. Are you currently in good health?	☐	☐
20. Is there anything else you think you should tell me?	☐	☐

Please specify _____

21. Are you pregnant?	☐	☐

If so, what month? _____

CONFIDENTIAL DENTAL HISTORY

	Yes	No
1. Are you having any discomfort at this time?	☐	☐
2. Have you been under regular care by a dentist?	☐	☐

3. How long since your last dental visit? _____

4. What was done at that time? _____

_____

5. Do your gums feel tender or swollen?	☐	☐
6. Have you ever been given local anaesthetic (freezing)?	☐	☐
7. Any complications with question #6?	☐	☐

Please specify _____

8. Are you aware of any lump or swelling in your mouth?	☐	☐
9. Are you satisfied with the appearance of your teeth?	☐	☐
10. Are you anxious to keep your natural teeth?	☐	☐
11. Are you tense during your dental visits?	☐	☐

12. Describe in your own words what you would like to have done with your teeth _____

_____

13. Do you currently experience (circle the appropriate one)

Loose teeth	Bleeding gums	Sore gums
Sensitive teeth	Bad breath	Popping or clicking in the jaw joints
Ear ache	Neck pain	
Headache	Unexplained nosebleed	Missing teeth
Spaced or crooked teeth	Unsatisfactory dentures	Gagging

14. Have you had previous gum treatments?	☐	☐
16. Have you ever had orthodontic treatment?	☐	☐

CONSENT FOR TREATMENT

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

I do hereby authorize you to release to and obtain from my physician and dentist any and all information relating to my health and for so doing this shall be your good and sufficient authority.

Patient's (Parent's) Signature _____ Date _____