Name:_____ Date of Birth:_____ Age:___

Address:_____

No. Street Apt. City Prov Postal Code

Home tel ( )_____ Work tel ( )_____ Cell ( )_____

Occupation:_____Employer:_____

Physician name and tel :_____ ( )_____

Emergency Contact and tel :_____( )_____

Referring friend or family member:_____

Dental Insurance: Yes__ No__ Company Name_____ ID_____

Policy No._____

Are you presently under the care of a physican? (pregnancy, high BP, cancer, other) Yes No

Explain_____

Have you ever been hospitalized for any surgeries? Yes No

Do you have a heart or circulatory problem of any kind? Yes No

Have you ever fainted, had chest pain, or shortness of breath? Yes No

Do you bruise easily or have prolonged bleeding? Yes No

Have you ever taken cortisone or steroids? Yes No

Do you have any prosthetics of any kind? (artificial joints, pacemaker, heart valve, pins, screws) Yes No

Do you have any allergies? (latex, medications: penicillin, codeine, local anaesthetics etc.) Yes No

List:_____

Are you presently taking any medications?

Drug_____ Reason_____

Drug_____ Reason_____

Drug_____ Reason_____

Drug_____ Reason_____

Drug_____ Reason_____

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

Anemia	Heart murmur	Kidney trouble	Smoking now
Arthritis	Heart trouble	Liver trouble / hepatitis	Stroke
Asthma	Herpes /cold sores	Mental or nervous disorder	Thyroid trouble
Blood disorder	High or low blood pressure	Pregnant now	Tuberculosis
Cancer	HIV / AIDS	Rheumatic fever	Scarlet fever
Epilepsy	Hyper or hypoglycemia	Other _____	

Have you ever had an illness, condition or medical alert not listed above?

Explain_____

CHILDREN: Have you had any of the following recently: Chicken Pox Measles Mumps Strept throat Tonsillitis Sinus or ear infection. Yes No _____

CONSENT FOR TREATMENT: This is to certify that I, the undersigned, have provided correct medical information, and consent to receive the performance of dental and oral surgery procedures agreed to be necessary or advisable, including the use of x-rays and local anaesthetic as indicated, and I will assume responsibility for all fees associated with those procedures.

Signature _____ Date_____

Patient Parent Guardian

Please tell us your reason for selecting our dental office: (friend referral, found us on internet, newspaper, received a mailing advertisement, saw our building sign in mall, other)

_____

Please describe in your own words your 1. CC - chief complaint or reasons for making this dental visit: (for example; new patient with no problems, gums bleed or sore, broken tooth, lost filling, pain to hot, cold, sweets, or chewing, gum or facial swelling, second opinion or quote, orthodontic consultation, denture problem,) Please state 2. Area of problem, how long it has been present and if getting worse.

1.CC_____

_____

_____

2._____

Dentist has reviewed Medical History:_____ Date:_____

MEDICAL ALERTS:_____BP:_____