



Date: _____

Patient Information:

A parent or guardian will be responsible for decisions on my treatment: Yes No

Name _____

First

Initial

Last

Address _____

Street

Apt.

City

Prov

Postal Code

Date of Birth: ____/____/____
DD/MM/YYYY

Email _____

Work Tel. (____)____-____

Mobile Tel. (____)____-____

Home Tel. (____)____-____

Emergency Contact _____

Relationship _____

Tel. (____)____-____

Family Doctor _____ Tel. (____)____-____

Dental History:

1. What is the reason for your visit? Emergency Exam Other _____
2. How frequently do you see the dentist? 3-6 months Other _____
3. When was your last dental visit? _____ Last X-rays? _____
4. How often do you brush per day? _____ How often do you floss? _____
Do you use anti-bacterial rinse? Yes No
5. Are your teeth sensitive to: Cold Heat Sweets Other _____
6. Do your gums bleed when: Brushing Flossing Never
7. Do your gums feel swollen or tender? Yes No
8. Do you have bad breath or a bad taste in your mouth? Yes No
9. Do your jaws crack, pop or grate when you open widely? Yes No
10. Do you grind or clench your teeth? Yes No
11. Do you have food catch between your teeth? Yes No
12. Have you ever had local anaesthetic (freezing)? Yes No
Any Complications? Specify: _____
13. Have you ever had any problems with previous dental treatments? Yes No
Specify: _____
14. Have you ever had any of the following: Bridgework Crowns or Caps Root Canal
 Full or Partial Denture Orthodontics Periodontal (Gums)
15. Are you satisfied with your teeth? Yes No Specify: _____
16. Are you nervous about dental treatment? Yes No

Medical History: (this information will be confidential)

1. Are you presently under the care of a physician? Yes No
If so please explain: _____
 2. Have you ever been hospitalized? Yes No
Please explain: _____
 3. When was your last medical checkup? _____
 4. Are you taking any drugs or medication at this time? Yes No
- | | | | |
|------------|--------------|------------|--------------|
| Drug _____ | Reason _____ | Drug _____ | Reason _____ |
| Drug _____ | Reason _____ | Drug _____ | Reason _____ |
| Drug _____ | Reason _____ | Drug _____ | Reason _____ |

5. Have you ever had any adverse effect to any of the following: Latex Penicillin Aspirin
 Benzodiazepines Codeine Demerol Local Anesthetic Nitrous Oxide
 Other _____
6. Have you ever been warned against any other medications? Yes No
 Which? _____
7. Have you ever taken prolonged medical or non-medical drugs? Yes No
 Which? _____
8. Do you suffer from any allergies? Yes No Which? _____
9. Do you bruise easily or have prolonged bleeding? Yes No
10. Do you smoke? How much per day? Yes No
11. Have you ever fainted, had shortness of breath or chest pains? Yes No
12. Do you have or have you ever had any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> Glandular Disorders | <input type="checkbox"/> Malignant Hypothermia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental/Nervous Disorder |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Head/Neck Injuries | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Anorexia Nervosa | <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Organ Transplant/Implant |
| <input type="checkbox"/> Artificial Hearth Value | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Heart Pacemaker/ Surgery | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Artificial Joints (hips, knees) | <input type="checkbox"/> Heart Rhythm Disorder | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stomach/Intestinal Problems |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> H.I.V. Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hodgkin's Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hyper (hypo) Glycaemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cortisone/Steroid | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Drug/Alcohol Dependence | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease | |

Children: Have you recently had any of the following (approx. date)?

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Strep Throat _____ | <input type="checkbox"/> Tonsillitis _____ | <input type="checkbox"/> NONE |

Women: Are you pregnant? Yes No Using birth control? Yes No Are you breastfeeding? Yes No Menopause? Yes No

General Release:

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by my dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature Patient Parent/Guardian

Print Name

Date