

WELCOME TO OUR OFFICE

NAME _____

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

PHONE: RESIDENCE _____ BUSINESS _____ DATE OF BIRTH _____

REFERRED BY _____ PHYSICIAN _____

OCCUPATION/EMPLOYER _____

PERSON RESPONSIBLE FOR ACCOUNT _____

INSURANCE CARRIER _____ GROUP NO. _____ S.I.N. _____

BASIC _____ % PROSTH. _____ % CROWN/BRIDGE _____ %

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional services. All information will be kept strictly confidential.

Please check (✓) YES NO

1. Have you ever had a serious illness or are you under the care of a physician now?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had a medical examination in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you use any medicine now? Please list any	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had any of the following diseases? (Please Circle)	<input type="checkbox"/>	<input type="checkbox"/>
hepatitis, jaundice, diabetes, high blood pressure, tuberculosis, any lung disease, venereal disease, heart attack, heart murmur or heart disease, stroke, epilepsy, cancer, thyroid disease, kidney disease, mental or nervous disease, asthma, rheumatic fever, stomach problems, blood disorders.		
5. Have you been exposed to the Hepatitis virus?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been exposed to the HIV (AIDS) virus?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever needed antibiotics for dental treatment in the past?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever experienced any unusual reaction and/or allergic reaction to any of the following drugs? aspirin, penicillin, iodine, sulfonamide (sulfa), barbiturates (sleeping pills), local anaesthesia or other medicine.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you bruise easily or bleed abnormally?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had any injury or surgery to your face or jaws?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a prosthetic implant (i.e.artificial limbs, etc.)?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. WOMEN ONLY - Are you pregnant (Which month?)	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have any disease, condition or problem not listed above that you think the doctor should know about? If yes, please explain.....	<input type="checkbox"/>	<input type="checkbox"/>

When was your last cleaning and check-up? _____

DENTAL HISTORY

1. If there was a simple way to whiten your teeth, would you be interested?	<input type="checkbox"/>	<input type="checkbox"/>
2. Why did you leave your last dentist?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any oral habits such as clenching, grinding your teeth or nail biting?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been shown how to floss or brush?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a bad reaction to dental anaesthetic? When	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you awaken with pain in your teeth or jaws? How often?	<input type="checkbox"/>	<input type="checkbox"/>
7. What concerns you most about your dental health?	<input type="checkbox"/>	<input type="checkbox"/>

8. Are you satisfied with the appearance of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>

TREATMENT AUTHORIZATION

I, the undersigned consent to the dental treatment agreed upon and that I am financially responsible to my dentist for the entire treatment. I understand that the fees may not be covered by or may exceed my plans benefits.

Date _____

Patient's Signature