

Welcome To Our Dental Office

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION ON BOTH SIDES.

PERSONAL INFORMATION

Date _____
Day Month Year

Name _____

Address _____ Date of Birth _____ Age _____

City _____ Home Phone _____

Postal Code _____ Office Phone _____ Ext. _____

Occupation _____ Title: Mr. / Miss / Mrs. / Ms.

Name of Employer _____ Medical Doctor _____

Email _____

Name of person responsible for this account _____

Do you have dental insurance? _____

Company Name _____

Policy No. _____ % Covered _____

I.D. or S.I.N. No. _____

How did you hear about our practice? _____

MEDICAL HISTORY

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you ever had a serious illness, operation, or been hospitalized?
If Yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you under the care of a physician now for any problem?
If Yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had a medical examination within the last year?
If Yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you taken any medicines, drugs or pills presently?
If Yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken or been given bisphosphonate medication or any of its family? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have or have you ever had any of the following? (Circle) | | |
| Rheumatic Fever | | Thyroid Disease |
| Heart Trouble | | Lung Disease |
| High Blood Pressure | | Asthma |
| Heart Murmur | | Blood Disorders |
| Venereal Disease | | Anemia |
| Mental or Nervous Disease | | Cancer |
| Joint Replacement | | Sinusitis |
| Liver Disease (Jaundice, Hepatitis) | | |
| Kidney Disease | | |
| Diabetes | | |
| Epilepsy | | |
| Radiation or X-ray Disease | | |
| Gastrointestinal Disease | | |
| AIDS | | |
| Other _____ | | |
| 7. Do you have any allergies?
If Yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you allergic to any medicines or drugs?
If Yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 9. Have you ever had freezing (local anaesthetic) in your mouth?
Any ill effects from it? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you bleed abnormally? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever fainted? When? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have any chest pains? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do your ankles ever swell? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you gained or lost excessive weight recently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever taken cortisone or steroids? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Is there any history of family disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Is there anything that the dentist should know regarding your medical history
that has not been mentioned?
Explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. To the best of your knowledge, are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| WOMEN: Are you pregnant?
If yes, in what stage of pregnancy? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

DENTAL HISTORY

1. Have you ever had a complete dental examination with a full series of dental x-rays within the past 3 years? Yes No
2. Last dental visit? _____ What was done? _____
3. Have you had any extractions? Yes No
If yes, did you experience prolonged bleeding after? Yes No
4. Have you ever had any of the following dental treatments? (Circle)

Root Canal	Orthodontics	Full or partial denture
Periodontal (gums)	Crowns or Caps	Bridgework
5. Are you aware of bad breath or a bad taste in your mouth? Yes No
6. Have you ever had a bad experience at the dentist? Yes No
7. What is your present dental problem? _____

Dentist Signature _____ Date _____

PATIENT/GUARDIAN APPROVAL AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

I also consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume the responsibility for fees associated with these procedures.

Signature _____ Date _____