



DATE: _____

Name: (Mr / Ms / Miss / Mrs) _____ DOB _____
Surname First Initial Preferred DD MM YYYY

Address: _____
Street APT City Postal Code

Home: _____ Work: _____ Cell: _____

EMAIL _____ Health Card # _____

Family Physician: _____ Office Number: _____

Emergency Contact: _____ Number: _____ Relationship: _____

How did you hear about our office? Google online Yellow Pages Yellow Pages Online
Other _____ Friend _____ Family _____

Dental Insurance Information YES NO

Primary Insurance

Primary Insurance Company _____ Employer/ School _____
Policy number _____ Certificate/ID # _____
Subscriber's name _____ Subscriber's DOB _____ Relationship to you _____
(DD/MM/YYYY)

Secondary Insurance

Primary Insurance Company _____ Employer/ School _____
Policy number _____ Certificate/ID # _____
Subscriber's name _____ Subscriber's DOB _____ Relationship to you _____
(DD/MM/YYYY)

* All information is strictly private, and is protected by doctor-patient confidentiality.

1. Please circle YES or NO for each of the following conditions that pertain to your health:

chest pain	Yes	No	tuberculosis	Yes	No	bleeding problems	Yes	No
angina or stroke	Yes	No	heart murmur	Yes	No	fainting spells	Yes	No
shortness of breath	Yes	No	liver disease	Yes	No	heart attack	Yes	No
arthritis	Yes	No	HIV/AIDS	Yes	No	asthma	Yes	No
diabetes	Yes	No	high blood pressure	Yes	No	cancer	Yes	No
stomach ulcers	Yes	No	rheumatic fever	Yes	No	hepatitis	Yes	No
blood disorders	Yes	No	seizures (epilepsy)	Yes	No	lung disease	Yes	No
anemia	Yes	No	kidney disease	Yes	No	pacemaker	Yes	No
congenital heart defect	Yes	No	eating disorder	Yes	No	steroid therapy	Yes	No
drug/alcohol dependency	Yes	No	prosthetic heart valve	Yes	No	smoke/chew tobacco	Yes	No

specify & quantity

Have you been treated for any other medical condition not listed above? YES or NO

2. Has there been any change in your general health in the past year?

3. When was your last medical checkup?

4. Are you taking any prescription or non-prescription drugs of any kind? YES or NO If yes, please list:

5. Do you have any allergies? YES or NO If yes, please list below.

- a) Medications
- b) Latex/rubber products
- c) Other ex. Hay fever, foods

6. Are you currently taking, or have taken in past, Bisphosphonate (bone building) medications?

Such as: Fosamax, Boniva, Actonel, Skelid, Loran, Bonefos, Didronel YES or NO If yes, please explain:

7. Have you ever had a peculiar or adverse reaction to any medicines or injections? YES or NO If yes, please explain:

8. Do you have a prosthetic or artificial joint? (Knee or hip replacement) YES or NO

If yes when was procedure completed?

9. Have you ever been advised by a medical doctor or dentist to take antibiotics before dental treatment? Yes or No

If yes, please explain:

10. Have you ever been hospitalized for any illnesses or operations? YES or NO

If yes, please explain:

11. Have you ever had surgery or radiation therapy for a tumor, growth or cancer? YES or NO

12. When was your last dental visit?

13. Are you satisfied with the current appearance of your teeth? If no why?

14. Are you nervous visiting the dentist? YES or NO

15. Please inform us of any pertinent dental or health information we may need to know to provide you with the best possible care.

Financial Information/Consent for Services

Our office policy states that services are to be paid in full at each visit as they are performed. In certain circumstances financial arrangements for payments may be available. All professional services are charged directly to the patient who is personally responsible for the payment of account. We will gladly complete insurance forms and reports for processing so you can obtain the re-imbusement. Although insurance is a contract between yourself, your employer, and the insurance company, we will try to help you understand your policy whenever possible.

In order to best serve all our patients we do require a 48 hour notice to change or cancel a scheduled appointment.

Failure to provide adequate notice will result in a fee being charged to your account.

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

PATIENT/PARENT/GUARDIAN SIGNATURE Date:

DENTIST SIGNATURE