Dental Health Clinic

Patient Information

Name _____
First Last

Date of Birth _____ Age _____ ☐ Male ☐ Female
Day Month Year

Mailing Address _____ City _____ Postal Code _____

Home Phone _____ Business _____ Cell _____
Occupation _____ Employer _____
Referred by _____ Email Address _____
Previous Dentist _____
Reason for today's visit ☐ Examination ☐ Emergency ☐ Other _____
Physician _____ Phone Number _____
In case of emergency notify _____
Relationship _____ Phone Number _____

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it will be necessary to charge for the time lost. Office policy is that services are paid at each visit as they are performed.

CONFIDENTIAL MEDICAL HISTORY

1. Date of last medical examination _____
2. Are you presently under the care of a physician? ..... ☐ Yes ☐ No
   Please specify _____
3. Are you presently taking any pills, drugs or medication? ☐ Yes ☐ No
   Please Specify _____
4. Have you taken prolonged medication in the past? ☐ Yes ☐ No
   Prescription or Non Prescription _____ please specify _____
5. Have you had rheumatic fever? ..... ☐ Yes ☐ No
6. Have you had heart disease or murmur? ..... ☐ Yes ☐ No
7. Do you become breathless easily? ..... ☐ Yes ☐ No
8. Have you had abnormal bleeding? ..... ☐ Yes ☐ No
9. Have you taken cortisone or steroids? ..... ☐ Yes ☐ No
10. Have you any allergies? ..... ☐ Yes ☐ No
11. Have you had allergies to any drugs or medicines? ..... ☐ Yes ☐ No
    Ie. Penicillin. Please specify _____
12. Have you ever been hospitalized and was surgery performed?..... ☐ Yes ☐ No
    Please Specify _____
13. Are your feet often swollen? ..... ☐ Yes ☐ No
14. Have you gained or lost excessive weight recently? ..... ☐ Yes ☐ No
15. Do you or have you had? Please circle

High Blood Pressure	Anemia	Herpes	Epilepsy	Asthma
Low Blood Pressure	Sinus Problems	Arthritis	Cancer	Stroke
HIV/AIDS	Migraine Headaches	Diabetes	Ulcer	Psychiatric Care
Kidney disease	Tuberculosis	Thyroid Problems	Hepatitis	Scarlet Fever
Fainting Spells	Venereal Disease	Liver Disease	Chest Pain	Heart Trouble
Lung Disease	Blood Disorder	Hyper (Hypo) Glycaemia		Mental or Nervous Disorder

16. Are you presently in good health? ..... ☐ Yes ☐ No
17. Do you have any disease, condition or problem not listed above that you think the doctor should know about? ..... ☐ Yes ☐ No
    Please specify _____
18. (Women Only) Are you pregnant? If so, what month? _____ ☐ Yes ☐ No
19. Do you use tobacco products? If so, how long? _____ ☐ Yes ☐ No

CONFIDENTIAL DENTAL HISTORY

1. Are you having any discomfort at this time? ..... ☐ Yes ☐ No
   Please specify _____
2. Have you been under regular care by a dentist? ..... ☐ Yes ☐ No
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Do your gums feel tender or swollen? ..... ☐ Yes ☐ No
6. Have you ever been given general anesthetic? ..... ☐ Yes ☐ No
7. Any complications with # 6? ..... ☐ Yes ☐ No
   Please specify _____
8. Are you aware of any lump or swelling in your mouth? ..... ☐ Yes ☐ No
9. Are you satisfied with the appearance of your teeth? ..... ☐ Yes ☐ No
10. Are you anxious to keep your natural teeth? ..... ☐ Yes ☐ No
11. Are you tense during dental visits? ..... ☐ Yes ☐ No
12. Are you interested in a method to calm your nerves? ..... ☐ Yes ☐ No
13. Describe in your own words what you would like to have done with your teeth _____
    _____
    _____

14. Do you currently experience: Circle appropriate one(s)

Loose teeth	bleeding gums	sore gums	sensitive teeth
Bad breath	ear ache	neck pain	headache
Missing teeth	gagging	spaced or cracked teeth	
unexplained nose bleeds	popping or clicking in the jaw joints		unsatisfactory dentures

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures. I the undersigned, certify that all the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Patient's (Parent's) Signature _____ Date _____