PATIENT NAME:_____ **DATE:**_____
Address:_____ City:_____ PC :_____
Birthdate:_____ SIN #_____ • Single • Married • Divorced • Separated
Home Phone: _____Work Phone:_____ Cell Phone:_____
Email : _____
Employer:_____ Ins. Co._____ Group#_____Cert#_____
Present Position:_____ How long held:_____
Spouse (or other person responsible for payment) Name:_____
Address: _____City:_____ Prov:_____
Employer:_____ Ins. Co. _____ Group#_____ Plan#_____
Present position:_____How long held:_____Work ph_____
Email address: _____
In case of emergency call: Name:_____ Number:_____
I first learned about this dental office from: • Yellow pages • Internet • School • Work
Referred by: • Another patient, friend • Another patient, relative • Doctor/staff member
• Other:_____ Name of person who referred:_____

DENTAL HISTORY
Have you been having any specific problems? • Yes • No Describe:_____
Last dental visit?:_____ Purpose:_____ Last complete exam:_____
Has fear of discomfort kept you from regular visits?: • Yes • No
How do you describe your dental health? • Good • Fair • Poor
Do you think you have: Decay? • Yes • No Gum Disease? • Yes • No
Home care: Brush? • Yes • No Floss? • Yes • No Water Jet? • Yes • No
Do your gums ever bleed? • Yes • No How often?_____
Are you troubled with bad breath?: • Yes • No
How do you feel about ever losing your teeth? _____
Have you had any unusual effects from previous dental treatment? • Yes • No

MEDICAL HISTORY (Confidential. Repeated every 5 years) Date:_____
MD's Name:_____Last physical:_____Age:_____
(Women)Are you pregnant? • Yes • No Expected Due Date:_____
Are you under a doctor's care now? • Yes • No If so, for what reason?_____
Are you taking any medications, pills, drugs? Please List:_____
• Heart problems • Measles • Diabetes • Hepatitis • Prosthetic Valves/Joints • HIV/AIDS
• Mumps • Arthritis • Low Blood Pressure • High Blood Pressure • Scarlet Fever • Malignancies
• Venereal Disease• Circulatory problems• Typhoid Fever • Radiation treatment • Herpes • Excessive bleeding
• Nervous problems • Asthma • Tuberculosis • Anemia • Psychiatric Care • Stroke • Sinus problems
• Rheumatic fever • Hospitalization • Ulcer • Tonsilitis □ Birth Control Pill or Patch
• Allergy to anaesthetics:_____ • Allergy to medicines/drugs: _____
□ Medical Condition other than listed above: _____
Have you had any other serious illness? • Yes • No Explain:_____
Have you been hospitalized in the last 2 years? • Yes • No Why?_____
Do you prefer Nitrous Oxide Sedation? • Yes • No
Do you wish to talk to the doctor about any problem not listed? • Yes • No

Authorization: I hereby authorize the doctor and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.
Patient Signature:_____ Date:_____