



Welcome

Thank you for selecting us as your dental team. We will strive to provide you with the best dental care. To help us meet all your dental needs, please complete the entire form. If you have any questions, please ask - we will be happy to help.

Patient# _____

SIN# _____

Date _____

Patient Information (Confidential)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ Prov. _____ P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ Prov. _____ P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Reason For Your Visit

What Brings You To Us Today:

General Dentistry Dental Emergency _____ Smile Improvement _____

Are You Happy With Your Smile? Would You Like To Discuss Any Of The Following Treatments:

- Smile Makeover Closing Gaps In Your Smile
 Veneers Clear Braces
 Dental Implants Dentures
 Teeth Whitening Options Other: _____

Insurance Information

Name of Insured _____ Relation to Patient _____

Birthdate _____

Insurance Company _____ Group# _____ Policy ID# _____

Insurance Co. Address _____ City _____ Prov. _____ P.C. _____

Patient Medical History

Physician _____ Office Phone _____ Date of last Exam _____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... Yes No
If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medication(s) are you taking? _____
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes No
5. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes No
6. Do you use tobacco? Yes No
7. Do you use controlled substances? Yes No
8. Do you have or have you had any of the following?

High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Swollen Ankles..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever / Allergies..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting/Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequently Tired..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy / Convulsions..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis / Jaundice..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problem..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are you wearing contact lenses? Yes No
10. Are you allergic to or have you had any reactions to the following? Local Anesthetics (e.g. Novocain)..... Yes No
Penicillin or any other Antibiotics..... Yes No
Sulfa Drugs Yes No
Barbiturates Yes No
Sedatives..... Yes No
Iodine..... Yes No
Aspirin..... Yes No
Any Metals (e.g. nickel, mercury, etc.)..... Yes No
Latex Rubber..... Yes No
Other (please list) _____
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes No
12. Women Only:
 - a) Are you pregnant or think you may be pregnant?..... Yes No
 - b) Are you nursing?..... Yes No
 - c) Are you taking oral contraceptives?..... Yes No

Patient Dental History

Name of Previous Dentist and Location _____ Date of last Exam _____

1. Do your gums bleed while brushing or flossing?..... Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes No
4. Do you feel pain to any of your teeth?..... Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw?

Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No
Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth?..... Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past?..... Yes No
12. Have you ever had any prolonged bleeding following extractions?..... Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
16. Do you like your smile? Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) _____ Date _____

Doctor's comments _____

Signature _____ Date _____