CONFIDENTIAL PATIENT INFORMATION

We appreciate referrals, whom may we thank for referring you _____

Date: _____

Dr. Mr. Mrs.
Ms. Miss Mst.

NAME: _____
FIRST LAST INITIAL

How would you prefer to be addressed?

_____

Please list other family members attending this office.

_____

ADDRESS: _____
STREET UNIT # CITY PROV. POSTAL CODE

HOME PHONE _____ BUSINESS _____ OTHER _____

EMAIL _____ FAX _____

DATE OF BIRTH _____ SEX _____ OCCUPATION _____
DAY/MONTH/YEAR

EMPLOYED BY _____

IN CASE OF EMERGENCY _____

NAME & DATE OF BIRTH OF INSURED MEMBER

_____

PERSON RESPONSIBLE FOR ACCOUNT: SAME AS ABOVE ❒ OR _____

_____
NAME ADDRESS

MEDICAL HISTORY

1. DATE OF LAST MEDICAL EXAMINATION _____

2. NAME OF PHYSICIAN _____ PHONE _____

3. IS YOUR PHYSICIAN TREATING YOU NOW? IF **YES**, PLEASE SPECIFY ❒ YES ❒ NO

_____

4. ARE YOU ON MEDICATION? IF **YES** PLEASE LIST MEDICATION ❒ YES ❒ NO

_____

_____

_____

_____

5. DO YOU HAVE DRUG ALLERGIES? e.g.. Penicillin ❒ YES ❒ NO

IF YES PLEASE SPECIFY _____

_____

_____

6. HAVE YOU EVER HAD OR BEEN TREATED FOR?

Respiratory Disease	❒ Yes	❒ No	High Blood Pressure	❒ Yes	❒ No
Hepatitis	❒ Yes	❒ No	Herpes	❒ Yes	❒ No
Tuberculosis	❒ Yes	❒ No	Rheumatic Fever	❒ Yes	❒ No
Low Blood Pressure	❒ Yes	❒ No	Anemia	❒ Yes	❒ No
Stroke	❒ Yes	❒ No	Liver Problems	❒ Yes	❒ No
Scarlet Fever	❒ Yes	❒ No	Abnormal Bleeding	❒ Yes	❒ No
Sinus	❒ Yes	❒ No	Ulcer	❒ Yes	❒ No
Heart Disease	❒ Yes	❒ No	Shortness of Breath	❒ Yes	❒ No
Nervous Problems	❒ Yes	❒ No	Arthritis	❒ Yes	❒ No
Epilepsy	❒ Yes	❒ No	Dizzy Spells	❒ Yes	❒ No

please complete other side

continued from other side

Thyroid Problems	❒ Yes	❒ No	Blood Disorders	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	Asthma	❒ Yes	❒ No
Chest Pains	❒ Yes	❒ No	Kidney Problems	❒ Yes	❒ No
Aids or HIV Positive	❒ Yes	❒ No	Drug Dependence	❒ Yes	❒ No
Psychiatric Problem	❒ Yes	❒ No	General Allergies	❒ Yes	❒ No
Heart Murmur	❒ Yes	❒ No	Disease of Eyes, Ears,		
Latex Allergy	❒ Yes	❒ No	Nose or Throat.	❒ Yes	❒ No
Hip, knee or joint replacement	❒ Yes	❒ No	Cancer	❒ Yes	❒ No

7. ARE YOU PREGNANT? ❒ Yes ❒ No MONTH _____

8. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH?

PLEASE SPECIFY (INCLUDE SURGERY) _____

_____

_____

_____

DENTAL HISTORY

1. Are you having discomfort at this time? ❒ Yes ❒ No Please Specify

_____

2. Have you been under regular care by a dentist? ❒ Yes ❒ No

3. Previous dentist? _____ Last visit? _____

_____

4. What was done at this time? _____

_____

_____

5. Do your gums feel tender or swollen? ❒ Yes ❒ No

6. Are you aware of any lump or swelling in your mouth? ❒ Yes ❒ No

7. Do you wear a full or partial denture ❒ Yes ❒ No

8. Do you have dental implants? ❒ Yes ❒ No

9. Have you ever had a problem with local or general anesthetic ❒ Yes ❒ No

10. Are you tense during dental visits? ❒ Yes ❒ No

11. Would you be interested in improving the appearance of your teeth? ❒ Yes ❒ No

12. Describe in your own words what you would like done with your teeth.

_____

_____

13. Do you currently experience?

loose teeth	❒ Yes ❒ No	bleeding gums	❒ Yes ❒ No	sore gums	❒ Yes ❒ No
sensitive teeth	❒ Yes ❒ No	bad breath	❒ Yes ❒ No	popping or clicking	
earache	❒ Yes ❒ No	unexplained nose bleed	❒ Yes ❒ No	in the jaws joints	❒ Yes ❒ No
spaced or crooked teeth	❒ Yes ❒ No	unsatisfactory dentures	❒ Yes ❒ No	missing teeth	❒ Yes ❒ No
				gagging	❒ Yes ❒ No

CONSENT:

I, _____ (name), consent to the performing of the dental procedures agreed to be necessary or advisable for myself or _____ (Patients Name) / _____ (relationship), and furthermore, I will assume responsibility for fees associated with those procedures.

Signatures _____ Date _____

I authorize release, to my insuring company/plan administrator, the information contained in claims submitted electronically.

_____ Signature of Patient

_____ Parent /Guardian

_____ Witness

_____ Date