PERSONAL INFORMATION

Name:_____Date of Birth:_____/_____/_____
(Given Name) (Family Name) (Initial) Month Day Year

Address:_____Postal Code:_____
(City) (Province)

Telephone Number:_____
(Home) (Cell) (Email)

Occupation:_____Employer:_____

Referred By:_____

Emergency Contact Name:_____Number:_____

HEALTH QUESTIONNAIRE

The following information is needed to insure proper diagnosis and treatment. All information provided is **CONFIDENTIAL** and for our records only.

1. Are you currently under the care of a physician? Physician's Name_____Telephone_____ YES NO

2. Have you ever been seriously ill or hospitalized?_____ YES NO

3. Have you experienced uncommon bleeding associated with past extraction, surgery or trauma?_____ YES NO

4. Are you presently taking any medications or non-prescription drugs? Specify_____ YES NO

_____

Do you presently have or have ever had any of the following: (Please place a check)

HEALTH REVIEW
__Migraine headaches
__Earaches
__Trouble hearing
__Sinus concerns
__History of family disease
__Persistent cough
__Difficulty swallowing
__Feel thirsty much of the time
__Recent change of appetite
__Drawn-out bleeding after injury
__Bruise easily
__Shortness of breath
__Chest pains
__Heart palpitations
__Tendency to faint
__Fits, seizures or convulsions

SPECIFIC CONDITION
__AIDS
__Anemia
__Angina pectoris
__Arteriosclerosis
__Arthritis/Rheumatism
__Artificial joints/implants
__Blood disorder
__Cancer
__Congenital heart condition
__Cortisone/steroid therapy
__Diabetes
__Epilepsy
__Heart attack
__Heart murmur
__Heart trouble
__Hemorrhage
__Mental/nervous disorder
__Pacemaker/artificial valves
__Positive testing for HIV virus
__Scarlet Fever
__Stomach/intestinal problems
__Stroke
__Thyroid Problem
__Tuberculosis
__Tumors/growths
__Venereal disease

ALLERGIES/SENSITIVITIES
__Allergies_____
__Asthma
__Hay fever
__Hives/skin rash
__Unusual reaction to any drugs

__Painful, swollen joints
__History of broken bones
__Numbing/prickling sensations
__Urinate more than 6 times/day
__High risk group for AIDS

__Hepatitis (A, B, C or other)
__High (Low) blood pressure
__Hyper (Hypo) glycemia
__Infectious/communicable disease
__Kidney/bladder problems
__Liver Disease
__Lung Disease

HABITS
__Non-prescription drugs
__Alcoholic beverages
__Tobacco
__Other

FEMALES ONLY: Are you
__Pregnant (how many months____)
__Past menopause

DENTAL HISTORY

Have you ever had or do you now have any of the following: (Please place a check)

__Bridges
__Extractions
__Full Dentures
__Gum treatments
__Injuries to face/jaw
__Loose teeth
__Lost fillings
__Orthodontic treatment
__Partial Dentures
__Root canal fillings
__Sores/lumps in mouth
__Swelling in mouth/jaw
__Surgery in your mouth

1. Previous Dentist_____ Please Circle

2. Have you had routine dental care (annually) in the past?_____ YES NO

3. Have you ever been given oral hygiene instructions in: brushing flossing other

4. How often do you brush your teeth?_____

5. How often do you floss your teeth?_____

6. Do your gums bleed when: brushing flossing spontaneously

7. Are any of your teeth sensitive to: cold sweets heat other_____

8. Does food catch between your teeth?_____ YES NO

9. Have you ever had any complications with local anaesthetic?_____ YES NO

10. Does your jaw crack, pop or grate when you open wide?_____ YES NO

11. Do you have any of the following tendencies: clenching grinding nail biting

12. Is there anything you would like to change with your smile? Example: whitening//missing teeth_____ YES NO

_____

I, the undersigned, certify the above medical and dental information is accurate to my knowledge and I have not omitted any relevant information.
I consent to the dental treatment agreed upon, including the use of local anaesthetic as needed. I assume responsibility for payment of the corresponding fees associated with these procedures.

Signature Date

_____ _____

Patient Parent Guardian

I, the undersigned, understand that the office requires 48 hours notice of a change of appointment. If I do not provide this a fee will apply.

Signature Date

_____ _____

Patient Parent Guardian