Please be advised all Information is private and confidential
Please be sure to bring your insurance information to your first visit

We welcome you to our dental practice.

Patient Information

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Name: ______________________________
First Name Last Name

Address: ______________________________

City: __________ Province: __________ Postal Code: __________

Date of Birth: Day ____ Month ____ Year ________

Phone #: **Home:** __________ **Cell:** __________ **Email:** __________

Preferred Contact Method
☐ Text
☐ Email
☐ Call cell
☐ Call home

How did you hear about us?
☐ Flyers
☐ Drive/Walk by
☐ Online
Friends and family (who may we thank) __________
☐ Other

Emergency Contact Information

Emergency Contact Name: ______________________________

Phone:(____) __________ Relationship: __________

Today's Visit

Reason for this appointment? ______________________________

Do you have dental insurance? ☐ Yes ☐ No

Your Medical History

Family Physician: ______________________________ Phone Number: __________

Address: __________ City: __________ Postal Code: __________

Specialist: ______________________________ Phone Number: __________

Date of your last physical exam: __________ Date of your last visit with your doctor: __________

Would you consider yourself to be in good health?: ☐ Yes ☐ No

Have you been hospitalized in the past 2 years? ☐ Yes ☐ No Reason: __________

Have you had any surgeries? Date and reason: ______________________________

Do you smoke? ☐ Yes ☐ No

WOMEN only: Are you pregnant? ☐ Yes ☐ No

Please list all medications you are currently taking:

(PLEASE TURN OVER)

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Medical Conditions

Please indicate any conditions you currently have or have had in the past:

☐ Cancer
☐ High Blood Pressure
☐ Low blood pressure
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Stroke
☐ Heart Problems
☐ Artificial Heart Valve
☐ Mitral Valve Prolapse
☐ Heart Attack

☐ Blood / Bleeding Disorders
☐ Angina Pectoris
☐ Kidney Disease
☐ Osteoporosis
☐ Arthritis / Gout
☐ Thyroid Disease
☐ Pacemaker
☐ AIDS (HIV)

☐ Anemia
☐ Asthma
☐ Cold sores
☐ Liver Disease (Hepatitis A, B, C)
☐ Mental / Nervous Disorders
☐ Fainting/ Dizziness
☐ Sinus Trouble

☐ Heart Palpitations
☐ Epilepsy / Seizures
☐ Malignant Hyperthermia
☐ Crohn's Disease
☐ Ulcers /Stomach concerns
☐ Lung disease

☐ Drug / Alcohol Addiction
☐ Congestive Heart Failure
☐ Headaches
☐ Hernia
☐ Artifical Joints
☐ Hip / knee replacement
☐ Emphysema

Are you taking any blood thinners? *(Warfarin / Coumadin / Plavix / Aspirin / Other)* ☐ Yes ☐ No

List: ____

Are there any other medical concerns we should be aware of?______________________________

____

Allergies and Reactions

Please indicate which medications or materials you are allergic to, or have had a reaction to in the past:

☐ Aspirin (ASA)
☐ Ibuprofen (ADVIL)
☐ Acetaminophen (TYLENOL)
☐ Codeine (TYLENOL 1, 2 or 3)
☐ Percocet / Oxycocet

☐ Tetracycline
☐ Penicillin/Amoxicillin /Ampicillin
☐ Erythromycin
☐ Clindamycin

☐ Local Anaesthetic (Freezing)
☐ Latex
☐ Nitrous Oxide

☐ Chlorhexidine (PERIDEX)
☐ Metal Allergy
☐ Cephalosporins (KEFLEX)
☐ Sulfa Drugs

Other drugs or material allergies not listed above;

Patient Signature: ______________________________

Dentist Signature: ______________________________

Date:____________

For office use only

Insurance info: Policy # ____________________ ID# ____________________

Policy holder ____________________ Policy holder DOB ____________________