WELCOME TO OUR OFFICE

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION ON **BOTH SIDES**.

PERSONAL INFORMATION

Date_____
Day Month Year

Name _____

Address _____ Date of Birth _____ Age ____

City _____ Home Phone _____

Postal Code _____ Office Phone _____

E-Address _____

Alternate E-Address _____

Occupation _____ Sex ____ Marital Status _____

Name of Employer _____ Medical Doctor _____

Name of person responsible for this account _____

Do you have dental insurance? _____

Company Name _____

Policy No. _____ % covered _____

S.I.N. _____

Whom may we thank for referring you?

Name _____

Address _____

MEDICAL HISTORY **Yes No**

1. Have you ever had a serious illness, operation, or been hospitalized? ❑ ❑
   If yes, explain _____
2. Are you under the care of a physician now for any problem? ❑ ❑
   If yes, explain _____
3. Have you had a medical examination within the last year? ❑ ❑
   If yes, any problems? _____
4. Are you taking any medications (including non-prescription drugs) of any kind?
   If yes, please list; _____

_____

_____

_____

_____

PLEASE TURN OVER

5. Do you have or have you ever had any of the following? (Circle)

Rheumatic Fever	Stroke/TIA	Liver Disease (Jaundice)
Heart trouble, Heart attack	Mental or Nervous Disease	Hepatitis
Heart surgery	Epilepsy	AID or HIV infection
Heart transplant	Glaucoma	Sexually transmitted diseases
Pacemaker	Sinusitis	Blood disorders
Bacterial Endocarditis	Asthma	Anemia
Congenital Heart Problems	Lung Disease	Arthritis
Mitral Valve Prolapse	Tuberculosis	Joint replacement
Heart Murmur	Thyroid Disease	Cancer
Angina	Eating Disorders	Radiation or X-Ray therapy
Shortness of breath	Gastro intestinal disease	Chemotherapy
Swelling of feet, ankles, hands	Stomach ulcers	Diabetes
Fainting or Dizzy spells	Kidney Disease	Chemical dependency
High Blood pressure		

Other _____

	Yes	No
6. Is there anything that the dentist should know regading your medical history that has not been mentioned?	❑	❑
Explain _____		
7. Do you have any allergies?	❑	❑
Explain _____		
8. Are you allergic to any medicines/freezing (local anaeothetic)/Latex, rubber etc.?	❑	❑
If yes, explain _____		
9. Have you reacted adversely to any of the following?		
Penicillin or other antibiotics	❑	❑
Sedatives, barbiturates or sleeping pills	❑	❑
Aspirin	❑	❑
Codein	❑	❑
Latex	❑	❑
Other	❑	❑
10. Do you bleed abnormally?	❑	❑
11. Have you ever required a blood transfusion?	❑	❑
12. Do you use tobacco?	❑	❑
13. Do you smoke?	❑	❑
If so how many packs/day? _____		
14. Do you use recreational drugs (such as cocaine or amphetamines)?	❑	❑
15. Do you have alcohol on a regular basis?	❑	❑
16. Have you ever taken Fen-Phen or Redux?	❑	❑
17. Have you gained or lost excessive weight recently?	❑	❑
18. Is there any history of family disease?	❑	❑
19. Women Only		
• Are you pregnant?	❑	❑
If yes, in what stage of pregnancy? _____		
• Are you nursing?	❑	❑
• Are you taking any birth control pills?	❑	❑

20. Are you nervous during dental treatment? ❑ ❑

If yes, how nervous are you? (Please indicate by marking this scale below)

Not at all .....1.....2.....3.....4.....5.....Very Anxious

DENTAL HISTORY **Yes No**

1. Have you ever had a complete dental examination with a full series of dental x-rays within the past 3 years? ❑ ❑
2. Last dental visit? _____ What was done? _____
3. Previous Dentist (name, location & phone no.) _____
4. Have you had any extractions? ❑ ❑

   If yes, did you experience prolonged bleeding after? ❑ ❑
5. Have you ever had any of the following dental treatments? (Circle)

   Root Canal Orthodontics Full or Partial Denture Bite Plate
   Periodontal (Gums) Crown or Caps Bridgework
6. Have you had head, neck or jaw injuries? ❑ ❑

Yes No

7. Have you ever experienced any of the following problems in;

   Your Jaw ❑ ❑
   Clicking ❑ ❑
   Pain ❑ ❑
   Difficulty in opening/closing/chewing ❑ ❑
   Frequent headaches ❑ ❑
8. Do you clench or grind your teeth? ❑ ❑
9. Are you aware of bad breath or a bad taste in your mouth? ❑ ❑
10. Have you ever had a bad experience at the dentist? ❑ ❑

    Explain _____
11. What is your present dental problem?

    _____

    _____

    _____
12. If you could change anything about your smile, what would you change?

    _____

    _____

    _____

PLEASE TURN OVER

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. Should there be any change to my present health status in the future, I will advise the Dentist and the Hygienist. 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 payers and/or health practitioners.

OFFICE POLICY (Please read)

1. Please help us to maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore at least 24 hours NOTICE must be given if cancellation is absolutely necessary.
2. Office policy is that services are paid for at each visit as they are performed. However, in certain circumstances arrangements for payment may be made by consulting the doctor.
3. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE PATIENT AND PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THEIR ACCOUNTS. We will prepare any necessary forms or reports to help collect your benefits from insurance companies.

Signature of Patient or Parent if minor	Witness Signature	Date

Doctor's Comments _____

_____

_____

_____

Signature	Date

Medical Doctor's name _____

Medical Doctor's address _____

Medical Doctor's Phone # _____

Specialist Doctor's name _____

Specialist Doctor's address _____

Specialist Doctor's Phone # _____