

# Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## About You

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
First Last Mi Mr Mrs Ms Dr

Birthdate: Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

Home Address: \_\_\_\_\_

City Province Postal Code

E-mail Address: \_\_\_\_\_

Single  Married  Partnered  Divorced/Separated  Widowed

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Employer: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

## Insurance

### Primary Insurance

Dental Coverage?  Yes  No Insurance Co. Name: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's ID #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address of Policy holder (if different than patient): \_\_\_\_\_

City Province Postal Code

Insured's Birthdate: Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

### Secondary Insurance

Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's ID #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address of Policy holder (if different than patient): \_\_\_\_\_

City Province Postal Code

Insured's Birthdate: Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

## Spouse Information

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Birthdate: Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

### Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.

I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature

Date

# Medical History

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Are you pregnant?  Yes  No Week #: \_\_\_\_\_

Have you had any metal rods, pins or implants?  Yes  No

Are you taking any prescription / over-the-counter drugs?  Yes  No

Please list each one: \_\_\_\_\_

### Have you ever had any of the following diseases or medical problems

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia     | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters      |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS                               | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse               | <input type="checkbox"/> Y <input type="checkbox"/> N HIV                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                             | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                             | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion                  | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus                        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy              | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis                            | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect            | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                           | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing               | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema                          | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                           | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells                    | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches                 | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                           | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever                          | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Surgery             | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                       | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease             |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

### Are you allergic to any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin   | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex          | <input type="checkbox"/> Y <input type="checkbox"/> N Other        |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

# Dental History

Why have you come to the dentist today? \_\_\_\_\_

When was your last Dental visit? \_\_\_\_\_

Do you require antibiotics before dental treatment? Yes  No

Your current dental health is:  Good  Fair  Poor

Have you ever had a serious/ difficult problem associated with any previous dental work?  Yes  No

Do you floss daily?  Yes  No Brush daily?  Yes  No

Type of bristles on your toothbrush?  Hard  Medium  Soft

Have you ever had gum treatment?  Yes  No

Do your gums ever bleed?  Yes  No Ever Itch?  Yes  No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Do you clench or grind your teeth?  Yes  No

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Do you have any loose teeth?  Yes  No

Do you still have wisdom teeth?  Yes  No

Would you like fresher breath?  Yes  No

Would you like whiter teeth?  Yes  No

Are you happy with the way your smile looks?  Yes  No

If not, what would you change? \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Office Use Only

I verbally reviewed the medical / dental information with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

## Office Use Only

## Medical History Update

## Office Use Only

Has there been any change in your health status since your last visit? If Yes, please explain. Y N

\_\_\_\_\_

Has there been any change in your health status since your last visit? If Yes, please explain. Y N

\_\_\_\_\_

Has there been any change in your health status since your last visit? If Yes, please explain. Y N

\_\_\_\_\_

Has there been any change in your health status since your last visit? If Yes, please explain. Y N

\_\_\_\_\_

\_\_\_\_\_  
Patient Signature Date Dentist Signature

\_\_\_\_\_  
Patient Signature Date Dentist Signature

\_\_\_\_\_  
Patient Signature Date Dentist Signature

\_\_\_\_\_  
Patient Signature Date Dentist Signature