NEW PATIENT INFORMATION

NAME: LAST _____ FIRST _____

ADDRESS: _____ PHONE: HOME: _____

CITY/PROV.: _____ WORK _____ EXT _____

POSTAL CODE: _____ CELL _____

DATE OF BIRTH: _____ MARITAL STATUS: _____

EMPLOYER: _____ OCCUPATION: _____

WIFE/MOTHER/GUARDIAN: _____ HOME _____ WORK _____

HUSBAND/FATHER/GUARDIAN: _____ HOME _____ WORK _____

DEPENDENT CHILDREN (NAMES) _____

REFERRED BY: _____

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER
NAME OF COMPANY: _____	NAME OF COMPANY: _____
POLICY HOLDER: _____	POLICY HOLDER: _____
EMPLOYER: _____	EMPLOYER: _____
DATE OF BIRTH: _____	DATE OF BIRTH: _____
GROUP/PLAN#: _____	GROUP/PLAN#: _____
CLASS/DIVISION: _____	CLASS/DIVISION: _____
CERTIFICATE/ID#: _____	CERTIFICATE/ID#: _____
EMPLOYEE# / SIN: _____	EMPLOYEE# / SIN: _____
COVERAGE %: BASIC _____ MAX _____	COVERAGE %: BASIC _____ MAX _____
MAJOR _____ MAX _____	MAJOR _____ MAX _____
YEAR END: _____	
SUBMIT TO EMPLOYER: _____	SUBMIT TO EMPLOYER: _____

I consent to the performing of dental procedures agreed to be necessary and understand that responsibility for payment of the fees associated with dental services (in whole or any portion not covered by my insurance) is mine, due and payable at the time services are rendered unless other arrangements have been made.

I also consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependants dental care.

DATE: _____ SIGNATURE: _____

MEDICAL HISTORY CHIEF COMPLAINT

DATE

1) ( ) Yes ( ) No Are you currently under the care of a medical doctor for any conditions?

2) ( ) Yes ( ) No Have you taken any medicine or drugs during the past two years?

3) ( ) Yes ( ) No Are you allergic (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine or any drugs, medications or latex?

4) ( ) Yes ( ) No Have you been a patient in a hospital during the past two years?

5) ( ) Yes ( ) No Do you have any artificial joints? (i.e. Knee, hip)

6) ( ) Yes ( ) No Have you ever had any excessive bleeding requiring special treatment?

7) Check any of the following which you have had or have at present:

( ) Heart Disease	( ) HIV / AIDS
( ) Open Heart Surgery	( ) Liver Disease
( ) Rheumatic Fever	( ) Hepatitis A, B, or C
( ) Scarlet Fever	( ) Thyroid Disease
( ) Heart Murmur	( ) Frequent Headaches
( ) High Blood Pressure	( ) Cancer / Leukemia
( ) Angina Pectoris	( ) Hemophilia
( ) Stroke	( ) Sickle Cell Trait
( ) Kidney Trouble	( ) Venereal Disease
( ) Diabetes	( ) Epilepsy or Seizures
( ) Glaucoma	( ) Psychiatric Treatment
( ) Arthritis / Rheumatism	( ) Drug Addiction
( ) Asthma	( ) Alcohol Abuse
( ) Cortisone / Steroid Medications	( ) Sinus Trouble
( ) Tobacco use (Smoking, Chewing)	( ) Cold Sores
( ) TB	( ) High Cholesterol
( ) Emphysema	

8) Women ( ) Yes ( ) No a) Are you pregnant now?
( ) Yes ( ) No b) Are you practicing birth control?
( ) Yes ( ) No c) Do you anticipate becoming pregnant?

DENTAL HISTORY

1) ( ) Yes ( ) No Are you having dental pain?

2) ( ) Yes ( ) No Do you think you have gum problems?

3) ( ) Yes ( ) No Do you notice popping, clicking or soreness of the jaw or just in front of your ears?

4) ( ) Yes ( ) No Are you involved in any contact sports? (i.e. hockey, football, boxing, basketball)

5) ( ) Yes ( ) No Do you brush daily?

6) ( ) Yes ( ) No Do you floss daily?

7) ( ) Yes ( ) No Have you ever had problems with dental freezing (Local anaesthetic)?

8) ( ) Yes ( ) No Do you feel very nervous about having dental treatment?

9) ( ) Yes ( ) No Have you ever had a bad experience in a dental office?

10) a. When was your last dental visit? _____

b. What was done? _____

c. When were your last dental x-rays taken? _____

d. Who was your last dentist? _____

11) a. Do you wear complete or partial dentures? _____

b. How many years have you worn dentures? _____

c. How old are your present dentures? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medication changes, I will inform the dental staff at the next appointment without fail.

DATE _____ PATIENT OR GUARDIAN SIGNATURE _____ DENTIST SIGNATURE _____