patient information

Date: _____

Name: Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ _____
Last *First* *Middle*

Sex M ❑ / F ❑ Previous Name? _____ Date of Birth _____

Address _____

E-Mail _____ Home Phone _____ Bus. Phone _____

Occupation _____ Employer _____ School _____

Family Physician _____ Phone No. _____

In Case of Emergency notify: Name _____

Relationship _____ Phone no. _____

Dental Insurance ❑ yes ❑ no Name of Company _____

Insurance Policy and Certificate Numbers _____

Social Insurance No _____

Drivers Licence No _____

Referred by _____

Medical History (of patient being treated)

yes	no		
❑	❑	1.	Are you being treated for any medical condition at the present or have you been treated within the past year?
		2.	When was your last medical check-up? _____
❑	❑	3.	Has there been any change in your general health in the past year? _____
❑	❑	4.	Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If so, please list: _____
❑	❑	5.	Are you allergic to any medications? _____
❑	❑	6.	Are you allergic to latex, foods, creams or have any environmental allergies? If so, please list: _____
❑	❑	7.	Have you ever had peculiar or adverse reaction to any medications or injections (eg: general/dental anesthetics)?
❑	❑	8.	Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
❑	❑	9.	Do you have a prosthetic or artificial joint (eg: hip/knee)?
❑	❑	10.	Do your ankles swell?
❑	❑	11.	Are you on a special/restricted diet?
❑	❑	12.	Have you ever been advised by a doctor to take antibiotics before dental treatment?
❑	❑	13.	Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?)
❑	❑	14.	Have you ever had hepatitis, jaundice or liver disease?
❑	❑	15.	Do you have a bleeding problem or bleeding disorder?

Medical History

yes no

❑ ❑ 16. Have you or any of your family members been diagnosed with malignant hyperthermia?

❑ ❑ 17. Have you been hospitalized for any illnesses or operations? _____

women only:

❑ ❑ 18. Are you pregnant?

❑ ❑ 19. Do you take oral contraceptives?

Do you have or have you ever had any of the following? (please circle)

Diabetes	Chest pain, angina	Diet pill therapy	Tuberculosis
Stomach ulcers	Heart attack	Radiation therapy	Asthma
Arthritis	Rheumatic fever	Chemotherapy	Lung disease
Seizures (epilipsy)	Mitral Valve Prolapse	Steroid therapy	Shortness of breath
Thyroid disease	Heart murmur	Osteoporosis medication	
Kidney disease	Pacemaker	Emotional/nervous disorder	
Sinus problems	Stroke	Psychiatric care	
STD/ Venereal diseases	Fainting/dizziness	Eating disorder	
Herpes	High blood pressure	Drug/alcohol dependency	
Gerd/reflux	Heart problems		
Cancer	Glaucoma		

Dental History

yes no

❑ ❑ 1. Are you in any dental pain right now?

2. When was your last dental visit? _____

❑ ❑ 3. Do you have any growths/swellings in your mouth?

❑ ❑ 4. Have you ever had an injury, surgery or radiation therapy to your face/jaws?

❑ ❑ 5. Does food tend to get caught between your teeth?

❑ ❑ 6. Do you clench or grind your teeth?

❑ ❑ 7. Do you feel nervous about dental treatment?

❑ ❑ 8. Have you had nitrous oxide sedation in the past for dental treatment?

❑ ❑ 9. Are you interested in nitrous oxide sedation with dental treatment?

❑ ❑ 10. Do you smoke or use chewing tobacco products?

Do you or have you ever experienced: (please circle)

Braces	Missing teeth	Neck pain
Periodontal (gum) treatment	Unpleasant taste/odour in the mouth	Bleeding or irritated gums
Oral surgery	Cold sores/cankers	Headaches
Bite adjusted	Loose or shifting teeth	Tooth discomfort when chewing
Mouth guard	Snoring or sleeping disorders	Jaw joint pain
Sensitivity to temperatures or sweets		

Consent for treatment:

This is to certify that I, the undersigned, verify the above information is true. I consent to the performing of dental procedures agreed to be necessary or advisable and will assume responsibility for fees associated with such procedures. I have read the office's privacy policy and I am aware of circumstances where it may be necessary to release or to obtain patient information. I give permission for photographs to be taken at my dental appointments.

Date: _____

Signature: _____