PERSONAL INFORMATION

NAME MR. MRS. MS. MISS.____________________________________

ADDRESS____

CITY_____________PROVINCE____________POSTAL CODE______________

HOME PHONE___________________BUSINESS______________________ CELL______________

EMAIL____ DATE OF BIRTH_______________

REFERRED BY PATIENT____________________________WEBSITE Y/N GOOGLE Y/N

PHYSICIAN______________________________

OCCUPATION/EMPLOYER____

INSURANCE CARRIER____________________

POLICY HOLDER______________________ POLICY HOLDER BIRTH DATE________________

GROUP#______________________________ID #___________________________

EMPLOYER ____

DENTAL HISTORY

WHEN WAS YOUR LAST DENTAL EXAMINATION?_____________________________

ARE YOU HAPPY WITH YOUR SMILE? IF NOT, WHAT CONCERNS YOU MOST ABOUT YOUR DENTAL HEALTH?

____

MEDICAL HISTORY

HAVE YOU BEEN HOSPITALIZED RECENTLY? IF SO WHEN?

____

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING?

DIABETES	EPILEPSY
HIGH BLOOD PRESSURE	CANCER
HEART ATTACK WHEN?	THYROID DISEASE
HEART MURMOR OR HEART DISEASE	KIDNEY DISEASE
RHEUMATIC FEVER	MENTAL OR NERVOUS DISEASE
STROKE	JAUNDICE
ANY LUNG DISEASE	HEPATITIS (A/B or C)
ASTHMA	AIDS

OTHER____

HAVE YOU EVER EXPERIENCED ANY UNUSUAL REACTION TO ANY OF THE FOLLOWING?

PENICILLIN	ERYTHROMYCIN
CODEINE	LOCAL ANAESTHESIA
CLINDAMYCIN	OTHER MEDICINE
ASPIRIN	LATEX

DO YOU BRUISE EASILY OR BLEED ABNORMALLY? _________________

DO YOU HAVE ANY BLOOD DISORDERS SUCH AS ANAEMIA (THIN BLOOD)?

____

ARE YOU TAKING BLOOD THINNERS? __________________________________

DO YOU HAVE A PROSTHETIC IMPLANT? IF SO, WHEN? _______________

____

DO YOU HAVE A TENDENCY TO FAINT? _________________________________

WOMEN ONLY-ARE YOU PREGNANT? (WHICH MONTH?)_______________

ARE YOU TAKING ANY MEDICATIONS? PLEASE LIST___________________

____

DATE_______________PATIENT'S (PARENT/GUARDIAN) SIGNATURE______________