WELCOME TO OUR OFFICE

The following information is required to enable us to provide you with the best possible dental care. All the information you provide will be kept strictly confidential. As per RHPA.

Chart # _____

Medical Alert _____

Patient Information

The patient is an: ADULT ◉ CHILD ○ ADULT UNDER GUARDIANSHIP ○

Dr. ○ Mr. ○ Mrs. ◉ Ms. ○ Miss ○ Name of Guardian: _____

Name: _____
Last First Initial

Preferred Name: _____ Spouse's Name: _____

Address: _____
Street Apt. City Prov. Postal Code

Tel: ( ) _____ ( ) _____ ( ) _____
Home Work ext. Cell

E-Mail: _____ Preferred Contact Method: Home ○ Cell ◉ Work ○ E-mail ○

Date of Birth: ____/____/____ (dd/mm/yy) Sex: M ◉ F ○ Marital Status: _____

Emergency Contact: _____ Relationship: _____ Tel:( ) _____

Family Physician: _____ Tel: ( ) _____

Are other family members patients here? Yes ○ No ○ Names: _____

Whom may we thank for referring you? _____

CHILDREN ONLY:

School: _____ Grade: _____ Favorite Toy _____

Brothers/Sisters: _____

Employer Information

Employer: _____ Spouse's Employer: _____

Position/Title: _____ Position/Title: _____

Tel: ( ) _____ Tel: ( ) _____

Financial Information

Personal responsible for account: Self ○ Spouse ○ Other ○ _____

Method of payment: Cash ◉ Visa ○ MasterCard ○ AMEX ○ Debit ○ Insurance ○

O.H.I.P. #: _____

Driver's Lic. #: _____

Primary Dental Insurance

Ins. Name: _____

Ins. Company: _____ Tel: ( ) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID# _____

Max. Cov. _____ %Coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

Secondary Dental Insurance

Ins. Name: _____

Ins. Company: _____ Tel: ( ) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID# _____

Max. Cov. _____ %Coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

Medical History

1. Are you being treated for any medical condition at present or in the past year? If yes, please specify?
2. Have you been hospitalized in the past year?
3. What is the date of your last medical examination?
4. Are you presently taking any medications (prescription/over-the-counter/herbal? If yes, please list:
   1. 2. 3.
   4. 5. 6.
5. Have you ever had a reaction to any kind of medicine? If yes, please specify:
   Penicillin ☐ Sulfa ☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Local Anesthetic ☐
   Nitrous Oxide ☐ Other ☐
6. Do you have any allergies (medication, latex, hay fever, other)? If yes, please specify:
7. Do you bruise easily, or bleed excessively?
8. Do you smoke? How much per day?
9. WOMEN: Are you pregnant? ◯ Yes ◯ No Breastfeeding? ◯ Yes ◯ No Using birth control? ◯ Yes ◯ No Reached menopause? ◯ Yes ◯ No
10. Do you have or ever had any of the following? Please ✓ appropriate boxes

	Yes	No		Yes	No		Yes	No
A.I.D.S.	☐	☐	Epilepsy or seizures	☐	☐	Leukemia	☐	☐
Anemia	☐	☐	Fainting/dizzy spells	☐	☐	Lung disease	☐	☐
Angina pectoris	☐	☐	Glandular disorders	☐	☐	Lupus	☐	☐
Anorexia nervosa	☐	☐	Glaucoma	☐	☐	Malignant hyperthermia	☐	☐
Arthritis/rheumatism	☐	☐	Head/neck injuries	☐	☐	Mental/nervous disorder	☐	☐
Artificial heart valve	☐	☐	Heart disease/attack	☐	☐	Mitral valve prolapse	☐	☐
Artificial joints (hip, knee)	☐	☐	Heart murmur	☐	☐	Organ transplant/implant	☐	☐
Asthma	☐	☐	Heart pacemaker/surgery	☐	☐	Psychiatric treatment	☐	☐
Blood disorders	☐	☐	Heart rhythm disorder	☐	☐	Radiation/Chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis A/B/C	☐	☐	Rheumatic/Scarlet fever	☐	☐
Bulimia	☐	☐	Herpes	☐	☐	Sickle cell disease	☐	☐
Cancer	☐	☐	High/Low blood pressure	☐	☐	Sinus trouble	☐	☐
Circulation problems	☐	☐	H.I.V. positive	☐	☐	Stomach/intestinal prob.	☐	☐
Cholesterol	☐	☐	Hodgkin's disease	☐	☐	Stroke	☐	☐
Congenital heart lesions	☐	☐	Hyper (Hypo) glycemia	☐	☐	Thyroid disease	☐	☐
Cortisone/steroid	☐	☐	Hypertension	☐	☐	Tuberculosis	☐	☐
Crohn's disease	☐	☐	Inflammatory Bowel Disease	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	Jaundice	☐	☐	Venereal disease	☐	☐
Drug/Alcohol dependence	☐	☐	Kidney disease	☐	☐	Other	☐	☐
Emphysema	☐	☐	Liver disease	☐	☐	None	☐	☐

11. CHILDREN: Have you recently had any of the following (approximate date)?
    Measles ☐ Chicken Pox ☐ Tonsillitis ☐
    Mumps ☐ Strep Throat ☐ Other ☐
12. Are there other medical conditions we should know about?

Dental History

1. What is the reason for today's visit? Emergency ☐ Examination ☐ Other ☐
2. How frequently do you see a dentist? 3-6 months ☐ Annually ☐ Other ☐
3. When was your last dental visit? Last dental cleaning? Last X-Ray?
4. How often do you brush per day? Floss? Use anti-bacterial rinse?
5. Are your teeth sensitive to: Cold ☐ Sweets ☐ Heat ☐ Pressure ☐ Other ☐
6. Do your gums bleed when: Brushing ☐ Flossing ☐ Never ☐
7. Do your gums feel swollen or tender?
8. Do you have bad breath or a bad taste in your mouth?
9. Do your jaws crack, pop or grate when you open widely?
10. Do you grind or clench your teeth?
11. Does food catch between your teeth?
12. Have you ever had local anesthetic (freezing)?
    Any complications? Yes ◯ No ◯ Specify
13. Have you ever had any problems with previous dental treatment? Specify
14. Have you ever had any of the following: Bridgework ☐ Crowns or Caps ☐
    Full or Partial Dentures ☐ Orthodontics (braces) ☐ Periodontal (Gums) ☐ Root Canal ☐
15. Are you satisfied with your teeth? Specify
16. Any other dental concerns?

General Release

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the release of medical information from my medical doctor or other health provider as is required by your office. I will advise your office if there are any changes to my health status or any other information I have provided. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. To avoid cancellation charges, 2 business days notice required.

X _____ _____ Date: _____
Signature ☐ Patient ☐ Parent/Guardian Print Name

DDS
Signature: _____ _____ Date: _____