

Name _____ Preferred Name _____
Birthdate(dd/mm/yy) _____ Age _____ Marital Status _____ Spouse's Name _____
Address _____
City _____ Province _____ Postal Code _____
Phone #(Home) _____ (Work) _____ (Cell) _____ E-mail _____
Occupation _____ Employer _____
Whom may we thank for referring you to our practice? _____

Health History

Physician's Name _____ Phone # _____ Date of Last Visit? _____

Please list the following:

- Allergies (i.e. drugs, metals, latex?) _____
- Prescription medications/dosage _____
- Supplements or over the counter medications _____

Hospitalization or emergency care during the last 5 years? Reason? _____

Have you ever been treated for the following? (Please check those that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> S.T.D's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Other: _____ |

Do you smoke? How much? _____ Consume alcohol? How often? _____

Do you use recreational or street drugs? _____ Have you had a blood transfusion? _____

WOMEN: Are you pregnant? _____ Due Date _____

Dental History

Previous Dentist _____ Reason for Leaving _____

How often do you visit the dentist? _____ Date of last visit _____ Last X-rays _____

Oral Hygiene Habits:

- How often do you brush/day _____ Floss/day _____ Mouth rinse/day _____

Teeth Condition:

- Are your teeth sensitive to Heat? _____ Cold? _____ Sweets? _____ Chewing pressure? _____
- Have you ever had teeth removed? When? _____

Gum Condition:

- Do your gums bleed with brushing? _____ Flossing? _____ Do you have bad breath? _____

Jaw Condition:

- Do you have clicking, popping, or pain in your jaw? _____ Do you clench/grind your teeth? _____
- Headaches? _____ Jaw muscle stiffness in the morning? _____

Are you nervous or uneasy about having dental treatment? _____

Are you satisfied with your smile? _____ What would you change? _____

What is your immediate concern? _____

To the best of my knowledge the above information is correct. If I ever have any change in my health, I will inform the doctor or hygienist at my next appointment without fail.

Signature of patient, parent, or guardian

Date

So we can best meet your oral health objectives, please check all that apply.

I am interested to learn about:

- How oral health affects general health
- The dangers of silver (mercury) fillings
- The link between gum disease and heart disease
- Laser gum therapy
- The benefits of digital x-rays
- Sleep dentistry
- Dental implants
- Orthodontics
- Cosmetic dentistry
- Teeth Whitening
- Other _____

Insurance Information

Primary Insurance Company	Secondary Insurance Company
Subscriber: _____	Subscriber: _____
Relationship to Subscriber: _____	Relationship to Subscriber: _____
Birthdate of Subscriber: _____	Birthdate of Subscriber: _____
Group/Policy #: _____	Group/Policy #: _____
ID/Cert #: _____	ID/Cert #: _____
Employer: _____	Employer: _____