

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
- Dental implants
- Straightening teeth with Invisalign
- 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: