PERSONAL INFORMATION

Female ☐ Male ☐

NAME ______________________________

ADDRESS ______________________________

CITY ______________ PROVINCE ______________ POSTAL CODE ______________

PHONE: RESIDENCE ______________ BUSINESS ______________ DATE OF BIRTH ______________

REFERRED BY ______________ PHYSICIAN ______________

OCCUPATION/EMPLOYER ______________________________

PERSON RESPONSIBLE FOR ACCOUNT ______________ / P.I.N. NO. ______________

INSURANCE CARRIER ______________ GROUP NO. ______________ I.D# ______________

MEDICAL HISTORY

Please check (√) 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 checkup? Date ______________
3. Are you taking any medications, non-prescription drugs, supplements of any kind? .... ☐ ☐

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4. Do you have or have you ever had any of the following? (Please Circle) .... ☐ ☐

chest pain, angina	rheumatic fever	pacemaker	steroid therapy
heart attack	mitral valve prolapse	lung disease	diabetes
stroke	heart murmur	tuberculosis	arthritis
shortness of breath	blood pressure problem	cancer	seizures (epilepsy)
kidney disease	thyroid disease	hepatitis	jaundice

5. Have you ever been hospitalized for any illnesses or operations? .... ☐ ☐
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? .... ☐ ☐
7. Do you have a bleeding problem or bleeding disorder? .... ☐ ☐
8. Do you have allergies? .... ☐ ☐
9. Do you have or have you ever had asthma? .... ☐ ☐
10. Do you have a prosthetic or artificial joint? .... ☐ ☐
11. Do you have frequent headaches? .... ☐ ☐
12. Have you ever had any injury or surgery to your face or jaws? .... ☐ ☐
13. Women only: Are you pregnant? .... ☐ ☐
14. Do you have any condition or problem not listed above that you think the Dentist should know about? .... ☐ ☐

If yes, please explain ______________________________

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DENTAL HISTORY

1. Have you had a regular dental examination (annually) in the past year? .... ☐ ☐
2. Do you have any oral habits such as clenching, grinding your teeth or nail biting? .... ☐ ☐
3. Have you ever had tooth brushing instruction? .... ☐ ☐
4. Have you ever had instruction in using dental floss? .... ☐ ☐
5. What concerns you most about your dental health? ______________________________

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Date (D/M/Y) Guardian / Patient's Signature

NOTES ______________________________

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