Today's date: _	
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Patient Information (all information is strictly confidential and will remain with this office.)

Name:					
Last	First		Prefer to be called		
Address:					
Street	City	Prov	Postal Code		
Telephone:					
Home	Work		Cell		
Email:					
Date of Birth:Month / day / year	Age: Sex:	Marita	al Status:		
Employed by:	(	Occupation:			
How did you hear about our office	?				
Whom may we thank for referring you? Telephone:					
Medical Information					
Medical doctor:		Telephone: _			
Date of last physical exam:					
Are you presently under the care of	f a medical doctor:	If yes pleas	e specify		
Are you presently taking any medic	cation, including non-p	rescription, herbal su	ipplements and/or vitan	nins:	
Do you have any allergies or have yetc.):		O (medications, anesthetics,	metals, latex, antibiotics, pain kil	lers, dairy,	
Do you have to take antibiotics price		 es. whv?			
Have you had heart surgery? If yes					
Do you have any artificial prosthes					
Do you have abnormal bleeding?					
Do you have abnormal bleeding: _		_ Do you become bre	aciness easily:		
Do you have or have had any of th	ne following:				
	uberculosis Yes No	Hepatitis type Ye	es No <b>Hiv/aids</b>	Yes No	
Amenia Yes No H	eadaches Yes No	Chest Pain Y	<del></del>	Yes No	
Sinus problems Yes No H	erpes Yes No	Blood disorders Y	es No Digestive disorders	Yes N	
· —— ——	laucoma Yes No	Liver disease \			
	iabetes Yes No			Yes No	
	ancer Yes No	Rheumatic Fever			
	eart Trouble Yes No	Heart Murmur Y			
	Iney Trouble Yes No er Yes No	Emphysema Y Psychiatric care			
Alcohol/drug Dependency Yes No Ulc	er Yes No	Psychiatric care \	res No Stroke	Yes I	

Others:							
Do you smoke?	If so how much?	Do	o you take recreational drugs?				
Women: Are you taking	g Birth Control Pills?	Are y	you pregnant?				
This is to certify that I, the undersigned, consent to the performing or the procedures agreed to be necess or advisable and I will assume responsibility for fees associated with those procedures.  Signed:							
Account Information	on						
Person financially respo	onsible for the account:						
IF THE PATIENT IS UND	ER 18 YEARS OF AGE						
Father's Name:							
Father's address (if diff	erent than child):						
Father's telephone: Ho	me	Work	Cell				
Mother's Name:							
			Cell				
In case of Emergency	, place potify						
<u> </u>	•	Dolotio	nahin.				
			nship:				
			Cell				
Dental History							
•	comfort at this time? If yes p	olease specify:					
Have you been under t	he regular care of a dentist?						

Do you currentl	y experien	ice any	of the followin	 ng?				
Loose teeth	Yes	No	Ear ache	Yes	No	Spaced or crooked teeth	Yes	N
						Unexplained noose bleed		
						Popping or clicking of the jaw		
Bleeding gums Neck Pain			Headache	Yes	No	Unsatisfactory Dentures	Yes	N
Office Policy								
Vour annointmen	+ +: 0:	ha racan	and acpacially for	arvou Ifvo		able to keep your appointment w	o roquiro A	0 hau