

Today's date:	

Patient Information (all information is strictly confidential and will remain with this office)

Name:								
Last			First		Prefer to be called			
Address:								
Street			City	Pro	V	Postal Cod	e	
Telephone:								
Home			Work			Cell		
Email:								
Date of Birth:		Age:	Sex:		Marital	Status:		
Month / day /		_						
Employed by:			Occ	upation:				
How did you hear about our	office? _	_ Faceb	ook Google `	Yellow Pages	Frie	nd/Family Blog	Existing Pati	ients
Medical Information								
Medical doctor:				Telepho	one:			
Date of last physical exam:								
Are you presently under th	ne care o	f a med	ical doctor: Ye	es No If	yes ple	ease specify		
Are you presently taking a								
Do you have any allergies of etc.):		ou had	any reaction to (m	edications, anes	thetics, m	etals, latex, antibiotics, pain	killers, dairy,	
Do you have to take antibi		r to de	ntal work? If yes, v	why?				
Have you had heart surger								
Do you have any artificial p	rosthesi	s (Joint	s, heart valve, etc)	? If yes plea	se spec	ify:		
Do you have abnormal ble								
Do you have or have had a	any of th	e follov	wing:					
High blood pressure	Yes	No	Glaucoma	Yes	No	Heart murmur	Yes	N
							Yes	
Sinus problems						Psychiatric care _		
				Yes				
Head or Neck injuries								
Venereal Disease	Yes	 No	Ulcer	Yes	No	Anemia	Yes	
Nervous problems	Yes	 No	Hepatitis type	Yes	 No	Thyroid disease	Yes	
Radiation therapy	Yes	 No	Chest pain	Yes	 No	Arthritis	Yes	
Alcohol/drug dependency	Yes	No	Blood disorders	Yes	No	Epilepsy	Yes	
Tuberculosis	Yes	 No	Liver disease	 Yes	— No	Chemotherapy	Yes	
Headaches	Yes	 No	Asthma	 Yes	— No	Antidepressants _		
Herpes	Yes		Rheumatic Fever			Stroke	Yes	
Others:								

Do you smoke?							Yes	No	
Women: Are you to	aking Birth Cor	itrol Pills? Y	es No	Are y	ou pregnant? Y	es No			
This is to certify that I, the undersigned, consent to the performing or the procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.									
Signed:						_			
Account Informa	tion_								
Person financially r	esponsible for	the account:							
Dental History									
Are you having any	discomfort at	this time? If yes	s please sp	ecify: ₋					
Have you been und	that time?								
Do your gums feel si there often bleed									
Have you ever been				'es	No				
Have you ever had	_				-				
Are you aware of a									
Are you satisfied w					No				
Are you anxious to Are you tense during				0					
Are you interested				es	No				
Describe what you									
		·							
Do you currently	experience a	nv of the follo	wing?						
Loose teeth	•	•	_	_ No	Spaced or crooked	teeth	_Yes	No	
Bad Breath	Yes No	Gagging	Yes	No	Unexplained nose	bleeds	_Yes	No	
Missing Teeth									
Bleeding gums	_Yes No	Headache _	Yes	No	Unsatisfactory De	ntures	_ Yes	_ No	
Office Policy									
Your appointment 48 hours notice, ot		•			•	your appoint	ment we	require	
I understand that I	am ultimately	responsible for	the total f	ees ass	sociated with the tro	eatment per	formed.		
Date:		Patie	nt/ Guar	dian s	ignature:				