NAME _____ ❑ Male ❑ Female
Surname First - Please Print

ADDRESS _____ POSTAL CODE _____

CITY _____

PHONE - RESIDENCE _____ BUSINESS _____

CELL _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____

DATE OF BIRTH _____ AGE _____ AHC# _____
D / M / Y

PERSONAL PHYSICIAN _____ ADDRESS _____

HAVE DENTAL INSURANCE – Yes ❑ No ❑ INSURANCE COMPANY _____

GROUP NO. _____ I.D. NO _____ BASIC% _____ MAJOR% _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IN CASE OF EMERGENCY CONTACT _____

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional services. All information will be kept strictly confidential.

1. Are you now under the care of a physician? Yes ❑ No ❑
   (a) If so, what is the condition being treated?

   _____

2. Have you had any serious illness or operation or been hospitalized? Yes ❑ No ❑
   (a) If so, please explain.

   _____

3. Are you taking any drug or medicine? Yes ❑ No ❑
   (a) If so, what? _____
4. Are you allergic or have you reacted adversely to any drug or medicine: e.g. Yes ❑ No ❑
   local anaesthetic (freezing); Penicillin or other antibiotics;
   barbiturates, sedatives, analgesics (pain killers); Red Food Coloring?
5. Do you have or have you had any of the following diseases or problems:
   (a) Rheumatic fever or rheumatic heart disease? Yes ❑ No ❑
   (b) Congenital heart lesions? Yes ❑ No ❑
   (c) Cardiovascular disease: e.g. heart trouble; heart attack; high blood pressure; arteriosclerosis (hardening of the arteries); stroke? Yes ❑ No ❑
   (d) Chest pains or shortness of breath? Yes ❑ No ❑
   (e) Asthma, hay fever, skin rash? Yes ❑ No ❑
   (f) Fainting spells or seizures e.g. (epilepsy)? Yes ❑ No ❑
   (g) Diabetes? Yes ❑ No ❑
   (h) Kidney Disease? Yes ❑ No ❑
   (i) Hepatitis, jaundice or liver disease? Yes ❑ No ❑
   (j) Endocrine disorder: e.g. thyroid disease? Yes ❑ No ❑
   (k) Lung or breathing disorders: e.g. tuberculosis? Yes ❑ No ❑
   (l) Gastrointestinal disease: e.g. ulcers? Yes ❑ No ❑
   (m) Nervous disorder? Yes ❑ No ❑
   (n) Bone, muscle or joint disorder: e.g. arthritis? Yes ❑ No ❑
   (o) Cancer? Yes ❑ No ❑
   (p) Venereal Disease? Yes ❑ No ❑
   (q) Exposure to AIDS/HIV? Yes ❑ No ❑
6. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? Yes ❑ No ❑
   (a) Do you bruise easily? Yes ❑ No ❑
7. Do you have any blood disorder? Yes ❑ No ❑
8. Women - Are you pregnant? Yes ❑ No ❑
9. Do you have any disease or problem not listed above you think I should know about? Yes ❑ No ❑
   (a) If so, please explain _____

DENTAL HISTORY

1. Have you had a regular dental examination (annually) in the past? Yes ❑ No ❑
2. Do you have any oral habits such as clenching, grinding your teeth or nail biting? Yes ❑ No ❑
3. Have you ever had brush/floss instruction? Yes ❑ No ❑
5. What concerns you most about your dental health? _____

   _____

PATIENT (GUARDIAN) CONSENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of conscious sedation or local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.
I consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependents dental care.

Patient's (Parent's) Signature _____ Date _____

NOTES: _____

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