ACQUAINTANCE INFORMATION

PATIENT CODE	The data on this confidential form is essential if we are to render the best Professional care. We appreciate your co-operation in filling it out carefully So that we will have accurate records. Please print – Thank you.	ACCOUNT CODE

PERSONAL INFORMATION

PATIENT'S LAST NAME	FIRST NAME MIDDLE	GENDER (F / M)	HOME PHONE
HOME ADDRESS	APT.	CITY/TOWN	POSTAL CODE
E-MAIL ADDRESS			CELL PHONE
DATE OF BIRTH M / D / Y	OCCUPATION	EMPLOYER	BUSINESS PHONE
BUSINESS ADDRESS	BY WHOM WERE YOU REFERRED		MARTIAL STATUS
NAME OF SPOUSE	OCCUPATION		BUSINESS PHONE
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT	IN CASE OF EMERGENCY NOTIFY		

INSURANCE INFORMATION IF YOU HAVE A DENTAL PLAN PLEASE COMPLETE THE FOLLOWING

NAME OF INSURANCE COMPANY	POLICY/GROUP NUMBER	CERTIFICATE NUMBER
IS SPOUSE UNDER ANOTHER PLAN? ☐ YES ☐ NO	IF COVERED UNDER SPOUSE'S PLAN AS SECONDARY COVERAGE, PLEASE PROVIDE COMPANY NAME AND POLICY NUMBER & CERTIFICATE NUMBER	

DENTAL HISTORY

PREVIOUS DENTIST	ADDRESS	DATE OF LAST VISIT	PHONE

1. In past years have you been to a dentist on a regular basis? How often?	Yes	No	_____
2. Are you presently in any dental pain?	Yes	No	_____
3. Is any part of your mouth sensitive to temperature, pressure or sweets?	Yes	No	_____
4. Have you ever had orthodontic treatment?	Yes	No	_____
5. Do your gums bleed when brushing your teeth?	Yes	No	_____
6. Do you have an unpleasant taste or odour in your mouth?	Yes	No	_____
7. Do you have growths or swelling in your mouth? If yes, for how long?	Yes	No	_____
8. Have you ever had any wisdom teeth removed?	Yes	No	_____
9. Do you ever get food stuck between your teeth?	Yes	No	_____
10. Do you awaken with pain in your teeth or jaws?	Yes	No	_____
11. Do you have frequent headache or facial pain?	Yes	No	_____
12. Are you aware of jaw clicking or popping while eating or yawning?	Yes	No	_____
13. Do you ever get cold sores or fever blisters?	Yes	No	_____

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE INCLUDING THE USE OF LOCAL ANAESTHETIC AND/OR RELATIVE ANALGESIA AS INDICATED, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

MEDICAL HISTORY

PRESENT MEDICAL DOCTOR	**ADDRESS**	**PHONE NUMBER**

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAY BE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

☐ YES ☐ NO ☐ NOT SURE/MAY BE

5. Do you have any allergies? If you answered yes, please list using the categories below:

☐ YES ☐ NO ☐ NOT SURE/MAY BE

a) medications b) latex/rubber products c) other e.g. hay fever, foods

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAY BE

7. Do you have or have you ever had asthma?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

8. Do you have or have you ever had any heart or blood pressure problems?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

10. Do you have a prosthetic or artificial joint?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

12. Do you have any conditions or therapies that could affect your immune system

e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ YES ☐ NO ☐ NOT SURE/MAY BE

13. Have you ever had hepatitis, jaundice or liver disease?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

14. Do you have a bleeding problem or bleeding disorder?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAY BE

16. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ shortness of breath	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)	☐ drug/alcohol dependency
☐ heart attack	☐ prosthetic heart valve	☐ lung disease	☐ diabetes	☐ kidney disease	☐ stroke
☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	☐ cancer	☐ arthritis	☐ diet pill therapy

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?

18. Are there any diseases or medical problems that run in your family?
(e.g. diabetes, cancer or heart disease)

☐ YES ☐ NO ☐ NOT SURE/MAY BE

19. Do you smoke or chew tobacco products?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

20. Are you nervous during dental treatment?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

21. **For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?

☐ YES ☐ NO ☐ NOT SURE/MAY BE

To the best of my knowledge, the above information is correct:

PATIENT /PARENT/GUARDIAN SIGNATURE: **DATE:**

HYGIENIST SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**