DATE: \ \ **PATIENT INFORMATION**

PATIENT IS AN: ADULT ☐ CHILD ☐ ADULT UNDER GUARDIANSHIP ☐ NAME OF GARDIAN_____

Name _____ Nickname _____ Mrs.☐ Ms☐ Mr.☐
(last) (first) (initial)

Home Address _____
(street) (city) (prov.) (postal code)

Home Phone _(___)_____ Cellular Phone _(___)_____ Work Phone (___)_____

Date of Birth: _______________ Age:_____ Sex:_____ Marital Status:_____
M D Y

Family Physician: _____ Phone: _(___)_____

Medical Specialist (if presently under care) Phone: ( )

OCCUPATION:

Employed By:_____ Phone: _(___)_____ Ext._____

Spouse Employed By: Phone: ( ) Ext.

DENTAL INSURANCE: Yes☐ No☐ Group Policy # _____ Cerif. # _____

Primary Insurance Co. Name: _____ Yr. End_____

Coverage: Basic _____% Prosthetics_____% Crown/Bridge_____% Ortho_____% Perio Scaling _____%

Secondary Ins Co. Name: _____ Group Pol. #_____Certif. # _____Yr. End_____

Coverage: Basic % Prosthetics % Crown/Bridge % Ortho % Perio Scaling %

PERSON RESPONSIBLE FOR ACCOUNT: Self ☐ Other ☐ - Name _____

Address _____ Home Phone: _(___)_____

Business Phone ( )

IN CASE OF EMERGENCY: Please Notify _____ Relationship_____

Home Phone: _____ Business Phone: _____ Ext. _____

Is any other member of your family or relative a patient at our office?

REASON FOR TODAY'S VISIT Examination ☐ Emergency ☐ Other ☐ _____

Who may we thank for referring you to our office?

MEDICAL HISTORY PLEASE CHECK YES OR NO *IF NOT SURE*, CHECK *NS*	**NO**	**NS**	**YE S**	
Are you presently under Doctor's care? Why?				
Have you been under Doctor's care in the past two years? Why?				
Have you taken any medications, pills or drugs in the past two yrs?				If YES, list here:
Are you presently taking any medications, pills or drugs?				-
Are you presently taking any Natural Supplements? E.g., Vitamins				-
Have you ever had Tonsillitis?				
Have you been hospitalized in the past two years? (If yes, why?)				
Have you had any type of surgery? What and When When was your last complete physical examination?				
When walking, do you ever stop because of pain in your chest or shortness of breath?				
Are you on a prescription diet?				
Have you ever been diagnosed as having a tumor or cancer?				
Have you ever taken cortisone/steroid medication?				
Do you experience problems with healing?				
Do you wish to speak privately with the doctor about any problems?				
Do you smoke (if yes, how much?)				
Are you currently in good health?				
Do you bruise easily or bleed excessively				
Have you ever been warned about anesthetics risks?				

MEDICAL ALERT	**CONDITION**	**PREMEDICATION**	**ALLERGIES**	**ANAEST.**

ALLERGIES **Please check off any medications you are allergic to or you have reacted adversely to:**

☐ Ibuprofen (Advil)	☐ Nembutal	☐ Demerol	☐ Ampicillin	☐ Rovamycin	☐ Local Anaesthic (freezing)
☐ Aspirin	☐ Seconal	☐ Percodan	☐ Erythromycin	☐ Cedhalexin	☐ Nitrous Oxide
☐ Tylenol	☐ Naproxen	☐ Darvon	☐ Clindamycin	☐ Sulpha Drugs	☐ Amoxicillin
☐ Tylenol #2, #3, #4	☐ Toradol	☐ Penicillin	☐ Scopolamine	☐ Metal	☐ Chlorhexidene (Peridex)
☐ 222, 282, 292	☐ Codeine	☐ Valium	☐ tetracycline	☐ Latex	☐ Bandage

☐ **Food Allergies, pleas list:**

Please list any other medications or substances which you know you are allergic to:

MEDICAL CONDITIONS **Please check off all of the following conditions you presently have, or have had. (If not sure, check off NS)**

	No	NS	Yes		No	NS	Yes		No	NS	Yes
Malignant Hyperthermia				Scarlet Fever				Rheumatic Fever			
Stomach/Intestinal Problems				Kidney Trouble				Artificial Joints			
Tran dermal Nicotine Patches				Ulcers				Diabetes			
High Blood Pressure				Asthma				Hypoglycemia			
Low Blood Pressure				Hay Fever				Arthritis			
Heart Failure				Sinus Trouble				Rheumatism			
Congenital Heart Valve				Emphysema				Epilepsy / Seizures			
Heart Pacemaker				Frequent Cough				Glandular Disorder			
Heart Surgery				Lung Disease				Psychiatric Care			
Heart Murmur				Bronchitis				Mental/ nervous			
Mirtal Valve Prolapse				Tuberculosis				Disorders			
Chest Pain				Liver Disease				AIDS -HIVPositive			
Angina Pectoris				Hepatitis A				Venereal Disease			
Shortness of Breath				Hepatitis B				Herpes			
Stroke				Hepatitis C				Cold Sores			
Fainting or Dizziness				Yellow Jaundice				Fever Blisters			
Anemia				Thyroid Disease				Blood Disorders			
Cardiac Arrest/ Heart Attack				Glaucoma				Hemophilia			
Swelling of Feet/Ankles/Hand								Sickle Cell Anemia			
Drug or Alcohol Addiction				Cancer				Pain in Jaw Joints			
Chemotherapy				Head/Neck Injuries				X-ray/Cobalt Treatment			

If Yes, have you received treatment? Where?

Is there anything we have not mentioned that you think we should know regarding your medical history?

WOMEN ONLY Are you pregnant? Yes ☐ No ☐ Are you nursing? Yes ☐ No ☐

Are you taking Birth Control Pills? Yes ☐ No ☐ Are you taking Fertility drugs? Yes ☐ No ☐

Office visits are by appointment only and special times are set aside for lengthy office visits that require special procedures. This way, we can operate more efficiently with less waiting time and inconvenience. It is essential that each appointment be kept, it shows your level of commitment to your dental health. Missed appointments greatly inconvenience our staff in trying to rebook make-up appointments. ***Please remember that we require 2 of our business days notice, (our office is closed on Fridays), to avoid a cancellations fee.***

Signature: _____ **Date:** _____

Patient Authorization CDAnet

I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until undersigned revokes the same.

Signature of patient, parent or guardian: _____ **Date:** _____