PATIENT CODE

ACQUAINTANCE INFORMATION

ACCOUNT 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.**

PERSONAL INFORMATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	HOME PHONE
HOME ADDRESS	CITY/TOWN		POSTAL CODE
DATE OF BIRTH M D Y / OCCUPATION	EMPLOYER		BUSINESS PHONE
BUSINESS ADDRESS	BY WHOM WERE YOU REFERRED		MARITAL STATUS
NAME OF PARTNER	OCCUPATION		BUSINESS PHONE
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?	IN CASE OF EMERGENCY NOTIFY		PHONE #

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

NAME OF INSURANCE COMPANY

IS PARTNER UNDER ANOTHER PLAN ❑ Yes ❑ No

IF COVERDED UNDER PARTNER'S PLAN AS SECONDARY COVERAGE, PLEASE PROVIDE COMPANY NAME

MEDICAL HISTORY

PHYSICIAN	ADDRESS	PHONE

Are you currently under medical treatment? If so, for what: _____

Have you had an allergic or unusual reaction to: **(Please circle your answer to each question. If yes, please explain.)**

Aspirin	Yes	No	_____	Cosmetics	Yes	No	_____
Codeine	Yes	No	_____	Metals	Yes	No	_____
Dental Anaesthetic	Yes	No	_____	Other Medicines	Yes	No	_____
Penicillin	Yes	No	_____	Women: Are you pregnant?	Yes	No	Expected Date of Delivery _____

Have you ever been treated for any of the following:

AIDS/HIV	Yes	No	Glaucoma	Yes	No	Pain In The Chest	Yes	No
Anaemia	Yes	No	Hay Fever	Yes	No	Persistent Cough	Yes	No
Anorexia or Bulimia	Yes	No	Heart Attack	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Heart Defects	Yes	No	Rheumatoid Arthritis	Yes	No
Asthma	Yes	No	Heart Murmurs	Yes	No	Shortness Of Breath	Yes	No
Bleeding Problems	Yes	No	Heart Trouble	Yes	No	Seizures	Yes	No
Blood Disorders/Problems	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Bowel Problems	Yes	No	Hepatitis A, B or C (Liver Disease)	Yes	No	Skin Disorder	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Coughing Up Blood	Yes	No	Jaundice	Yes	No	Thyroid Problems	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Tuberculosis	Yes	No
Drug or Alcohol Dependency	Yes	No	Leukemia	Yes	No	Ulcer	Yes	No
Emphysema	Yes	No	Liver Problems	Yes	No	Venereal Disease	Yes	No
Epilepsy	Yes	No	Lung Disease	Yes	No	Other		
Gastrointestinal Disorders	Yes	No	Lupus	Yes	No			
			Mitral Valve Prolapse	Yes	No			

1. Have you ever been hospitalized or had a serious illness or had any surgery? ..... Yes No _____
2. Are you or have you received any psychiatric care and are you receiving medication for this? ..... Yes No _____
3. Are you being treated for any condition by a physician? ..... Yes No _____
   A. presently? Yes ❑ No ❑ _____
   B. in the last 2 years Yes ❑ No ❑ _____
4. Have you taken any drugs, pills, medicines or tablets in the last 2 years up to and including the present? ..... Yes No _____
5. Do you ever have asthma, hayfever, hives, skin rash? ..... Yes No _____
6. Have you ever had an adverse reaction to any drug including local anaesthetic (freezing) or general anaesthetic? ... Yes No _____
7. Are you allergic to latex? ..... Yes No _____
8. Do you have any other allergies? ..... Yes No _____
8. Have you had any unexplained weight loss, increasing thirst or appetite or increase in frequency of urination? Yes No _____
9. Have you ever taken cortisone? ..... Yes No _____
10. Do you bleed for a prolonged period of time when cut? ..... Yes No _____
11. Do you have any problems with healing when cut or bruised? ..... Yes No _____
12. Is there any history of disease in your family? ..... Yes No _____
13. Have you ever fainted? ..... Yes No _____
14. Is there anything that the dentist should know about your medical history that has not been mentioned? ..... Yes No _____
15. Are you pregnant or nursing? ..... Yes No _____
16. Are you presently taking any drugs or medicines? **(please circle)** ..... Yes No

Antibiotics or sulfa drugs	Drugs for heart trouble	Sedatives or sleeping pills
Anticoagulants (blood thinners)	High blood pressure medicine	Tranquilizers
Antidepressants	Insulin, Diabinese or similar drug	Water pills
Cortisone	Nitroglycerin	Other _____

17. Have you had any joint replacements? ..... Yes No _____
18. Have you ever or are you now receiving radiation therapy or chemotherapy? ..... Yes No _____
19. Do you have any in-dwelling catheters? ..... Yes No _____
20. Have you ever taken appetite supressant drugs, for example fenfluramine, phenteremine or dexfenfluramine? Yes No _____
21. Do you smoke? Yes No
    If so, how much. _____
22. Have we missed anything? _____

Patient's Signature _____ Medical history taken by _____ Date _____

DENTAL HISTORY

PREVIOUS DENTIST	ADDRESS	DATE OF LAST VISIT	PHONE

1. When was your last dental visit? _____
2. How often do you have a dental check-up? _____
3. Have you ever had an unfavourable experience at the dentist? ..... Yes No _____
4. Do you have any discomfort in your teeth due to hot, cold, sweets, biting or chewing pressure? ..... Yes No _____
5. Does food catch between your teeth? _____ If so, where? _____
6. Do your gums bleed when brushing or flossing? ..... Yes No _____
7. Are you conscious of bad breath or bad taste in your mouth? ..... Yes No _____
8. Do you favour one side when chewing? ..... Yes No _____
9. Are you unhappy with the appearance of your teeth, bite or smile? ..... Yes No _____
10. If you could, would you change anything about your smile? ..... Yes No _____
11. Do you consider your teeth beyond repair? ..... Yes No _____
12. Do you ever wake up with a headache or have a tired feeling in your face or jaws? ..... Yes No _____
13. Do your jaw joints pop, click or grate when opening widely? ..... Yes No _____
14. Do you clench or grind your teeth? ..... Yes No _____
15. Have you lost any teeth due to abscess, accident, decay or gum disease? **(please circle)** ..... Yes No _____
16. Was tooth replacement suggested? ..... Yes No _____

Please review your medical history on the other side. Indicate whether there is any change in your medical status, or if you are taking any new medications. Please indicate any changes below, with date and your signature.

1. _____
   DATE _____ SIGNATURE _____
2. _____
   DATE _____ SIGNATURE _____
3. _____
   DATE _____ SIGNATURE _____
4. _____
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    DATE _____ SIGNATURE _____
11. _____
    DATE _____ SIGNATURE _____
12. _____
    DATE _____ SIGNATURE _____
13. _____
    DATE _____ SIGNATURE _____
14. _____
    DATE _____ SIGNATURE _____

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.

_____ _____
PATIENT'S (PARENT'S, GUARDIAN'S) SIGNATURE DATE

 CHART NO. EM-DEE 12A58