About You

Today's Date (mm/dd/yy): ____________

Name: ____________
LAST FIRST M

I prefer to be called: ____________ ❑ M ❑ F

Birthdate: ___/___/___ SIN: ____________

Home Address: ____________

____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm#: (   ) ____________ Other#: (   ) ____________

Wk#: (   ) ____________ Email: ____________

Employer: ____________

Employer's Address: ____________

Occupation: ____________

Who may we THANK for referring you: ____________

Other family members seen by us: ____________

Spouse Information

His/Her Name: ____________

Employer: ____________

Wk#: (   ) ____________ SIN: ____________

Birthdate: ___/___/___ DL#: ____________

Person Responsible for Account

If other than you

Name: ____________

Wk#: (   ) ____________ Hm#: (   ) ____________

Billing Address: ____________

____

Relation: ____________ SIN: ____________

Employer: ____________ DL#: ____________

Dental Insurance

PRIMARY

Insurance Co. Name: ____________

Insured's Name: ____________

Group# (Policy#): ____________ ID#: ____________

Basic: ____________% Major: ____________%

Ortho: ____________% Maximum: ____________

SECONDARY

Insurance Co. Name: ____________

Insured's Name: ____________

Group# (Policy#): ____________ ID#: ____________

Basic: ____________% Major: ____________%

Ortho: ____________% Maximum: ____________

Emergency Contact

His/Her Name: ____________

Address: ____________ Relation: ____________

Wk#: (   ) ____________ Hm#: (   ) ____________

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ____________

Phone#: (   ) ____________ Date of last visit: ____________

Your current physical health is:
❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician?
❑ Yes ❑ No

Please specify: ____________

____

____

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Medical History *continued*

Are you taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

Please list each one:______________________________

____

Have you taken any prolonged medication in the past (prescription or non-prescription)? ❑ Yes ❑ No

Please specify:___________________________________

____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you taken cortisone or steroids? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems (please circle):

Heart (Surgery, Disease, Attack)
Chest Pain
Heart Murmur
High/Low Blood Pressure
Rheumatic Fever
Scarlet Fever
Arthritis/Rheumatism
Swollen Ankles
Stroke
Artificial Joints (hip, knee)
Kidney Problems
Ulcers
Diabetes
Thyroid Problems
Glaucoma
Emphysema
Difficulty Breathing
Neurological Disorders
Hospitalized/Surgery Performed
Psychiatric/Psychological Care
Tuberculosis
Asthma
Hay Fever
Sinus Problems
Radiation/Chemotherapy
Cancer
Hepatitis A (infectious)
Hepatitis B (serum)
Drug/Alcohol Abuse
Venereal Disease
A.I.D.S./H.I.V. Positive
Hemophilia
Sickle Cell Disease
Bruise Easily
Liver Disease
Abnormal Bleeding
Fainting/Dizzy Spells
Nervous/Anxious
Epilepsy/Seizures
Other ____________________

Are you allergic to any of the following? (please circle)

Local Anaesthetic
Codeine
Penicillin or other Antibiotics
Aspirin
Sulfa Drugs
Any Metals
Barbituates
Latex Rubber
Iodine
Other ____________________

Women only:

Are you pregnant or think you may be pregnant?
❑ Yes ❑ No Due Date:___________________________

Are you nursing? ❑ Yes ❑ No

Are you taking oral contraceptives? ❑ Yes ❑ No

Dental History

Reason for today's visit______________________________

Previous Dentist:_________________________________

Address:__________________Ph:(____)_______________

Date of last teeth cleaning:__________________________

Date of last dental x-rays:___________________________

Are you having any discomfort at this time? ❑ Y ❑ N

Please specify:___________________________________

Are you aware of any lump or swelling in your mouth? ❑ Y ❑ N

Are you satisfied with the appearance of your teeth? ❑ Y ❑ N

Are you anxious to keep your natural teeth? ❑ Y ❑ N

Are you tense during dental visit? ❑ Y ❑ N

Do you currently experience: (please circle)

Bad breath
Sore gums
Bleeding gums
Clicking or popping jaw
Spaced or crooked teeth
Grinding teeth
Loose teeth
Missing teeth
Broken filling
Sensitive teeth
Ear ache
Headache
Neck pain
Unexplained nosebleed
Unsatisfactory dentures
Gagging

Are you interested in whiter teeth? ❑ Y ❑ N

How often do you brush?____________________________

How often do you floss?_____________________________

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, as indicated and I will assume responsibility for fees associated with those procedures.
I hereby authorize the release of information contained in claims to be submitted electronically to my insuring company plan administrator.
I also consent to the collection, use or disclosure of personal information as is required for my dental care.
Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require two business days notice, otherwise it will be necessary to charge for the time lost.

____SIGNATURE________________________DATE________