PATIENT INFORMATION A Parent or Guardian will be responsible for decisions relating to my treatment Yes ☐ No ☐

Name: _____ (First / Initial / Last)

Address: _____ (Street / Apt. / City / Prov. / Postal Code)

Date of Birth: ____/____/____ (D/M/Y) Home Tel: (____)_____ Work Tel: (____)_____

Cell : _____ Email: _____

Family Dr. _____ Tel: (____)_____

Emergency Contact: _____ Tel: (____)_____

FINANCIAL INFORMATION This account will be paid by Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐

Person responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐ **(Please fill out if different than above)**

Name: _____ (First / Initial / Last)

Address: _____ (Street / Apt. / City / Prov. / Postal Code)

Date of Birth: ____/____/____ (D/M/Y) Home Tel: (____)_____ Work Tel: (____)_____

Driver's Lic.: _____ **OR** **SIN #:** _____ - _____ - _____

INSURANCE INFORMATION (If applicable)

Insurance Company: _____ Tel: (____)_____

Employer/Group Policy Holder _____ Insurance Year End: _____

Policy #: _____ Certificate #: _____ ID/SIN #: _____

Max. Coverage: _____ % Coverage for: _____ Basic _____ Major Restorative. _____ Orthodontic

MEDICAL HISTORY **(this information will remain confidential)**

	YES	NO
1. Are you presently under the care of a physician? If so explain _____	☐	☐
2. Have you ever had a serious illness or been hospitalized? If so explain _____	☐	☐
3. Are you taking any drugs or medication at this time? Drug _____ Reason _____	☐	☐
4. Do you suffer from any allergies (hay fever, latex etc.)? If so which ones? _____	☐	☐
5. Do you bruise easily or have prolonged bleeding?	☐	☐
6. Have you ever fainted, had shortness of breath or chest pains?	☐	☐
7. Have you ever been warned against using any medication? If so which? _____	☐	☐
8. Have you ever taken prolonged medical or non-medical drugs? Specify _____	☐	☐

9. Have you ever had an adverse effect to any of the following: **Aspirin** ☐, **Barbiturates** (sleeping pills)☐
Antibiotics -(Penicillin ☐, Sulfonamide ☐, other ☐), **Codeine** ☐, **Darvon** ☐, **Local Anaesthetic** ☐

10. **Women:**: Are you pregnant? Yes ☐ No ☐ Have you reached menopause? Yes ☐ No ☐ Are you taking birth control? Yes ☐ No ☐

11. Do you or have you ever had any of the following: **Please ☑ appropriate boxes**

☐ A.I.D.S	☐ Cancer	☐ Heart disease/attack	☐ Jaundice	☐ Rheumatic/Scarlet fever
☐ Anemia	☐ Circulation problems	☐ Heart murmur	☐ Kidney disease	☐ Sickle cell disease
☐ Angina pectoris	☐ Congenital heart lesions	☐ Heart pacemaker/surgery	☐ Liver disease	☐ Sinus Trouble
☐ Anorexia nervosa	☐ Cortisone/steroid	☐ Heart rhythm disorder	☐ Leukemia	☐ Stomach/intestinal prob.
☐ Arthritis/rheumatism	☐ Diabetes	☐ Hepatitis A/B/C	☐ Lung Disease	☐ Stroke
☐ Artificial heart valve	☐ Drug/Alcohol dependence	☐ Herpes	☐ Malignant hyperthermia	☐ Thyroid disease
☐ Artificial joints (hip, knee)	☐ Emphysema	☐ High/Low Blood Pressure	☐ Mental/nervous disorder	☐ Tuberculosis
☐ Asthma	☐ Epilepsy or seizures	☐ H.I.V. Positive	☐ Mitral valve prolapse	☐ Ulcers
☐ Blood Disorders	☐ Glandular disorders	☐ Hodgkins disease	☐ Organ transplant/implant	☐ Venereal disease
☐ Bronchitis	☐ Glaucoma	☐ Hyper (Hypo) Glycemia	☐ Psychiatric treatment	☐ Other _____
☐ Bulimia	☐ Head/neck injuries	☐ Hypertension	☐ Radiation/Chemotherapy	☐ None

12. **Children Only:** Have you recently had any of the following (approximate date): ☐ Chicken Pox _____

☐ Measles _____ ☐ Mumps _____ ☐ Strep Throat _____ ☐ Tonsillitis _____

DENTAL HISTORY

1. What is the reason for today's visit? _____

2. When was your last dental visit? _____ Last X-Ray? _____

3. Have you ever had local anaesthetic (freezing)? ☐ Yes ☐ No Any complications? ☐ Yes ☐ No Specify _____

GENERAL RELEASE: I, the undersigned, understand that the information contained in the dental and medical history portion of this chart is important to my treatment. I certify that the information is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ☐ Patient ☐ Parent ☐ Guardian Print Name Date