GENERAL INFORMATION Date_____

Name _____ Date of Birth _____

Address _____ Home# _____

City _____ Bus.#_____

Prov. _____ Post. Code _____ Cell#_____

Male ❑ Female ❑

Place of Employment _____

Hobbies/Sports _____

How did you hear about us? _____

IF UNDER 18:

Father's Name _____ Phone _____

Mother's Name _____ Phone _____

INSURANCE INFORMATION

Policy Holder _____ Date of Birth _____

Insurance Company Name _____

Policy/Group No. _____

I.D. No./Cert. No. _____ AHC No. _____

Coverage %: _____

BAS.	PRE.	C&B	ORTHO.	DENT.	Deductible (Y/N) $ _____
____%	____%	____%	____%	____%	Yearly Max. $ _____

2º Insurance _____

Policy Holder _____ Date of Birth _____

Policy/Group No. _____ ID/Cert. No. _____

MEDICAL AND/OR DENTAL UPDATES
(Please include any new medications, conditions, accidents, surgeries, etc.)

Date	Changes in Medical/Dental History	Signature

DENTAL HISTORY

Reason for Visit: _____

_____

Do you like the way your teeth look? Y / N

If 'No,' why not? _____

_____

Have you ever had:

- Orthodontic treatment ie. braces, etc. Y / N
- Periodontal treatment ie. gums Y / N
- Your teeth ground or bite adjusted Y / N
- Worn a bite plate or other appliance Y / N

Have you noticed any loosening of your teeth? Y / N

Does food tend to become caught between your teeth? Y / N

Do you suffer from pain and/or swelling of your gums? Y / N

Do you have any sore spots in your mouth? Y / N

Do your gums often bleed when you brush your teeth? Y / N

Problems of the jaw. Have you ever experienced:

- Clicking of the jaw? Y / N
- Pain (joint, ear, side of face)? Y / N
- Difficulty in opening and closing? Y / N
- Difficulty in chewing? Y / N

Habits. Do you:

- Clench or grind your teeth while awake or asleep? Y / N
- Bite your lips or cheeks regularly? Y / N
- Hold objects with the teeth (pens, pins, nails, fingernails)? Y / N

Do you feel apprehensive/scared when you receive dental treatment? Y / N

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the dentist at the next appointment.

_____ _____

Date Patient, Parent, or Guardian Signature

Medical Doctor (name and ph. no.) _____

Are you in good health? Y / N Are you currently being treated by a physician? Y / N

Date of last visit? _____ For what purpose? _____

_____

Are you currently taking any medications? Y / N Please list _____

_____

_____

Please check the box for any condition that you have had in the past or have now. Parents or guardian, if you are completing this form for your child, please indicate your child's health status by checking the appropriate box.

Cardiovascular

- Congestive Heart Failure ☐
- Heart Attack ☐
- Angina Pectoris or Chest Pain ☐
- High/Low Blood Pressure ☐
- Heart Murmur ☐
- Mitral Value Prolapse ☐
- Rheumatic Fever ☐
- Congenital Heart Defect ☐
- Artificial (prosthetic) Heart Valve ☐
- Arrhythmias ☐
- Heart Pacemaker or Defibrillator ☐
- Coronary Bypass ☐
- Coronary Angioplasty ☐
- Heart Transplant ☐
- Aneurysm ☐
- Other Heart Problem ☐

Hematologic

- Blood Transfusion ☐
- Anemia ☐
- Hemophilia ☐
- Leukemia ☐
- Sickle Cell Anemia ☐
- Prolonged Bleeding ☐

Neurologic

- Vision Problems ☐
- Glaucoma ☐
- Hearing Loss ☐
- Frequent headaches ☐
- Fainting or Dizzy Spells ☐
- Stroke ☐
- Epilepsy/Seizures ☐
- Psychiatric Treatment ☐

Gastrointestinal

- Ulcers ☐
- Colitis ☐
- Hepatitis A, B, or C ☐
- Liver Disease ☐
- Yellow Jaundice ☐
- Cirrhosis ☐
- Eating Disorder ☐

Pulmonary

- Hay Fever ☐
- Sinus Trouble ☐
- Asthma ☐
- Chronic Cough ☐
- Emphysema ☐
- Chronic Bronchitis ☐
- Tuberculosis ☐
- Breathing Difficulties ☐

Dermal/ Musculoskeletal

- Latex Allergy (Rubber) ☐
- Skin Rash ☐
- Night Sweats ☐
- Osteoarthritis ☐
- Rheumatoid Arthritis ☐
- Systemic Lupus ☐
- Artificial (Prosthetic) Joint Hip/knee replacement ☐

Endocrine/Hormonal

- Diabetes ☐
- Thyroid Disease ☐
- Taking Cortisone or other Steroid ☐

Genitourinary

- Kidney/Bladder Problem ☐
- Dialysis ☐
- Kidney Transplant ☐
- Sexually Transmitted Disease ☐
- HIV + / AIDS ☐

Other

- Frequent Sore throat ☐
- Head and Neck Pain ☐
- Tobacco Use ☐
- Alcohol Use ☐
- Injectable Drug Use ☐
- Drug or Alcohol Addiction recovering or current ☐
- Tumor or Cancer ☐
- Radiation Therapy ☐
- Chemotherapy ☐
- Disease, Problem, or Condition not listed ☐

Please list: _____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have reactions or allergies to drugs or medicines? Y / N List: _____

_____

Have you had an adverse reaction to Dental or General Anesthetic? Y / N

(WOMEN) Are you pregnant, possibly pregnant, or nursing? Y / N