## Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

			Patient #	
Dationat Informaciti	214		SS#/SIN	
Patient Information	) (CONFID	DENTIAL)	Date	
Name		Birthdate	Home Phone Zip State/ Zip Prov. P. C	/
Address		City	Prov. P. C	·
Email		Cell Phone		
Check Appropriate Box: ☐ Minor ☐ Sir If Student, Name of School/College	ngle □Married □	☐ Divorced ☐ Widowed ———— City ————	□ Separated State/ Ful ————————————————————————————————————	l Part ne □ Time
Patient or Parent/Guardian's Employer			Work Phone	
Business Address		City	State/ Zip Prov. P. C	
Spouse or Parent/Guardian's Name		(6)		
Whom may we thank for referring you?			Work Thorac	
Person to contact in case of emergency			Phone	
Responsible Party			1110/10	
Name of Person Responsible for this Accord	unt		Relationship to Patient	
Address			Home Phone	2
Email			Cell Phone	
		F: . 1 I	itution	
Driver's License#	Birthdate	Financial Insti	<i></i>	
Driver's License#				
Driver's License# Employer Is this person currently a patient in our of	fice? 🗆 Yes 🗆	Work Phone No	SS#/SIN	
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Patient Medical Hi	Story		
Physician	Office Phone	Date of Last Exam	
	Yes No		Yes No
1. Are you under medical treatment now?		9. Are you wearing contact lenses?	
2. Have you ever been hospitalized for any		10. Are you allergic to or have you had any reactions to the following?  Local Anesthetics (e.g. Novocain)	
surgical operation or serious illness within the		Penicillin or any other Antibiotics	HH
If yes, please explain		Sulfa Drugs	ПП
2 1 11 11 11 11		Barbiturates	
3. Are you taking any medication(s)		Sedatives	
including non-prescription medicine?		Iodine	
If yes, what medication(s) are you taking?		Aspirin	
4 II F. Di . (D. 1		Any Metals (e.g. nickel, mercury, etc.)	H
4. Have you ever taken Fen-Phen/Redux?		Latex Rubber Other (please list)	
5. Have you ever taken Fosamax, Boniva, Actonel		11. Do you have a persistent cough or throat clearing not	
medications containing bisphosphonates?  6. Do you use tobacco?		associated with a known illness (lasting more than 3 weeks)?	
7. Do you use controlled substances?		12. Women Only:	
1. Do you use controlled substances:		a) Are you pregnant or think you may be pregnant?	
8. Do you have or have you had any of the follow	uin a?	b) Are you nursing?	
		c) Are you taking oral contraceptives?	
	No	Yes No	Yes No
High Blood Pressure	Heart Disease		H
Rheumatic Fever	Cardiac Pacemaker Heart Murmur		HH
Swollen Ankles	Angina		HH
Fainting / Seizures Asthma	Frequently Tired	Tuberculosis	HH
Asthma	Anemia	Radiation Therany	H H
Low Blood Pressure	Emphysema	······································	
Epilepsy / Convulsions Leukemia	Cancer		
Diabetes	Joint Replacement or Im	plant Liver Disease	
Kidney Diseases	Hepatitis / Jaundice	Heart Irouble	
AIDS or HIV Infection	Sexually Transmitted D	sease Respiratory Problems	H
Thyroid Problem	Stomach Troubles / Ulca		HH
Acid Reflux	Osteoporosis		
Patient Dental Hist	F (1/4)		
- STORE TO CITCUIT TITLE	lory		
37 CD 1 D 1 17		Date of Last Exam	
Name of Previous Dentist and Location	Yes N		Yes No
Name of Previous Dentist and Location	Yes N	8. Do you have frequent headaches?	
Name of Previous Dentist and Location	Yes N ng?	8. Do you have frequent headaches? 9. Do you clench or grind your teeth?	
Name of Previous Dentist and Location	Yes N ng?	8. Do you have frequent headaches?	
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1. Do your gums bleed while brushing or flossi 2. Are your teeth sensitive to hot or cold liquid 3. Are your teeth sensitive to sweet or sour liqu 4. Do you feel pain to any of your teeth? 5. Do you have any sores or lumps in or near y 6. Have you had any head, neck or jaw injurie.	Yes N ng?	8. Do you have frequent headaches?	
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