PERSONAL, MEDICAL & DENTAL INFORMATION FORM

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. Please fill in the entire form.

PERSONAL INFORMATION

Salutation:

Last Name: First Name:

Name you would like to be called:

Street Address: Apt:

City: Postal Code:

Date of Birth (mm/dd/yyyy): E-mail:

Home Tel: Office Tel:

Occupation: Employer:

Physician: Previous Dentist:

Physician Tel:

Why have you decided to change dental offices?

How did you hear about us?

INSURANCE INFORMATION 1

Name of Insured if different from above:

Insurance Company:

Birth Date of Insured (mm/dd/yyyy):

Division (if applicable):

Policy/Group:

Employer:

Certificate ID:

Do you have secondary insurance?

INSURANCE INFORMATION 2

Name of Insured if different from above:

Insurance Company:

Birth Date of Insured (mm/dd/yyyy):

Division (if applicable):

Policy/Group:

Employer:

Certificate ID:

Do you have secondary insurance?

EMERGENCY CONTACT

Name:

Relationship:

Tel:

MEDICAL HISTORY

Are you being treated for any medical condition at the present or have you been treated within the last year?

Yes No

If yes, specify:

When was your last medical check-up?

Has there been any change in your general health in the past year?

Yes No

If yes, specify:

Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:

Yes No

Drug: Reason:

Drug: Reason:

Drug: Reason:

Do you have any allergies?

Yes No

If yes, specify:

Latex

Other

Have you had an unusual reaction to any drugs or medicines?

Yes No

If yes, specify:

Penicillin | Sulfonamide | Aspirin | Codeine
Local Anesthetic | Other

Have you ever taken cortisone or steroid medication?

Yes No

If yes, specify:

Do you have any sinus problems?

Yes No

If yes, specify:

Do you have or have you ever had any heart problems?

Yes No

If yes, specify:

Do you have a pacemaker?

Yes No

If yes, specify:

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

Yes No

If yes, specify:

Do you have or have you ever had jaundice, hepatitis or liver disease?

Yes No

If yes, specify:

Do you have a bleeding problem or bruise easily?

Yes No

If yes, specify:

Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia, etc?

Yes No

If yes, specify:

Do you smoke?

Yes No

If yes, how much?

Have you ever been hospitalized for any serious illnesses or operations?

Yes No

If yes, specify:

Do you have any prosthetic or artificial joints?

Yes No

If yes, specify:

Do you have or have you ever had any of the following?

Chest Pain/Angina
Heart Attack
High Blood Pressure
Stroke
Tuberculosis
Arthritis
Emphysema
Epilepsy
Thyroid Disease
Diabetes
Asthma
Stomach Ulcers
Kidney Disease
Cancer
Chemotherapy/Radiation
Psychiatric Disorder
Drug/Alcohol Dependency

For Females: Are you pregnant or breast feeding?

Yes No

If yes, specify:

Any other conditions or problems of which the dentist should be aware of?

Yes No

If yes, specify:

DENTAL HISTORY

When was your last visit?

When did you last have dental x-rays?

How often do you brush your teeth?

How often do you floss your teeth?

Have you been seeing a dentist regularly?

Yes No

Do any of your teeth ache?

Yes No

If yes, specify:

Have you ever been advised to take antibiotics before dental appointments?

Yes No

If yes, specify:

Do your gums bleed when you brush?

Yes No

If yes, specify:

Do you have any pain when you chew?

Yes No

If yes, specify:

Do you feel that you have bad breath?

Yes No

If yes, specify:

Have you ever been in a motor vehicle accident or experienced any blows to your jaw?

Yes No

If yes, specify:

Have you ever had a dental implant surgery?

Yes No

If yes, who performed the surgery and when was it done?

Are you being followed-up by a dental specialist?

Yes No

If yes, specify:

Please list anything else not mentioned above regarding your past dental history:

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and not knowingly omitted any information. This information has been reviewed with me and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

______________________________	____________	______________________________	____________
Signature of Patient	DD/MM/YY	Reviewed by Dentist	DD/MM/YY