



Patient Name: _____ Title: _____
Last First Middle Mr./Mrs./Ms./Etc.

Gender: Male Female Family Status: Married Single Child Other Birthdate: _____/_____/_____

E-mail: _____ Phone: _____

Address: _____
Street City Prov. Postal Code
Home Work Cell

How did you hear about our office?: _____

Person to contact in case of emergency: _____

Your Physician's Name: _____
Address Telephone

Approximate date of your last medical exam: _____ Would you consider yourself to be in fairly good health? Yes No

Within last year, have there been any changes in your general health? Yes No

Have you ever had complications following dental treatment? Yes No

Do you use tobacco (smoking or chewing)? Yes No

Have you been hospitalized within the last 5 years due to surgery or illness? Yes No

Are you currently taking any prescription or non-prescription medication? Yes No

Please indicate if you currently have or have experienced any of the following:

- Allergy - Aspirin Allergy - Codeine Allergy - Penicillin Allergy - Sulphur Allergy - Erythromycin Allergy - Local Anaesthetic
- Anemia Arthritis Artificial Joints Asthma Blood Disease Blood Thinners Cancer Diabetes
- Dizziness/Fainting Emphysema Epilepsy Excessive Bleeding Excessive Bruising Glaucoma Hay Fever
- Head Injury Heart Disease Heart Murmur Hepatitis A Hepatitis B Hepatitis C High Blood Pressure
- HIV+ (AIDS) Jaundice Kidney Disease Liver Disease Low Blood Pressure Mental Disorders Multiple Sclerosis
- Nervous Disorders Osteoporosis Medication Pacemaker Radiation Treatment Respiratory Problems Rheumatic Fever
- Sinus Problems STD Stomach Problems Stroke Thyroid Disease TMJ Discomfort Tuberculosis Tumours Ulcers

If you have answered Yes to any of the previous questions, please explain: _____

Do you have any other health issues or allergies? _____

WOMEN ONLY: Are you pregnant? If Yes, when is the due date? _____

I hereby certify that the above information is accurate. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids and hereby give my consent for performance of dental treatment. I authorize the release of any pertinent information to third-party insurance carriers, payers and /or health care practitioners. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and agree to pay any said balance on my behalf or on behalf of my dependants (if any).

Signature: _____ Date: _____
Patient, Parent or Guardian