Name (Mr, Mrs, Ms):_____ Age:___Sex:___ Date of Birth:_____
Address:_____ Postal Code:_____
Phone: Res. _____ Bus. _____ Cell _____ Email Address:_____
Occupation:_____ Place of Employment:_____
Person Responsible for Account:_____
Dental Insurance: Policy Holder Name/DOB _____ Company:_____
Secondary Insurance:_____
Certificate/Policy No.:_____ Div. #:_____
Whom may we thank for referring you to our office?_____

MEDICAL HISTORY: Family Physician:_____ Clinic/Ph. #:_____

The following information is required to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality.

		CIRCLE	
1.	WHEN WAS YOUR LAST MEDICAL CHECK-UP?_____		
2.	ARE YOU TAKING ANY MEDICATIONS, NON-PRESCRIPTION DRUGS/MEDICATIONS OR HERBAL SUPPLEMENTS? If YES, please list: _____	NO	YES
3.	HAVE YOU HAD ANY UNUSUAL REACTIONS TO ANY DRUGS, MEDICATIONS OR INJECTIONS?_____	NO	YES
4.	DO YOU HAVE ANY ALLERGIES TO **PENICILLIN**, OTHER MEDICATIONS, LATEX/RUBBER PRODUCTS OR OTHER (foods, Hay fever, etc.)? _____	NO	YES
5.	HAVE YOU EVER HAD HEPATITIS, JAUNDICE OR LIVER DISEASE?_____	NO	YES
6.	DO YOU HAVE ABNORMAL BLEEDING OR BRUISING?_____	NO	YES
7.	HAVE YOU EVER TESTED POSITIVE FOR HIV, AIDS OR SEXUALLY TRANSMITTED DISEASES?_____	NO	YES
8.	HAVE YOU EVER BEEN ADVISED TO TAKE ANTIBIOTICS FOR PREVIOUS DENTAL TREATMENT? _____	NO	YES
9.	DO YOU HAVE ANY JOINT REPLACEMENTS OR PROSTHETIC PARTS?_____	NO	YES
10.	HAVE YOU HAD HEART DISEASE OR SURGERY? _____	NO	YES
11.	HAVE YOU EVER OR ARE YOU PRESENTLY TAKING STEROIDS OR CORTISONES?_____	NO	YES
12.	HAVE YOU EVER HAD RADIATION OR CHEMOTHERAPY FOR TUMORS OR CANCER? _____	NO	YES
13.	DO YOU SMOKE OR CHEW TOBACCO PRODUCTS?_____	NO	YES

14. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (please circle)

Chest pain/Angina	Shortness of Breath	Pacemaker	Rheumatic Fever
Heart Attack	Mitral Valve Prolapse	Stroke	High/Low Blood Pressure
Asthma/Breathing Problems	Diabetes	Kidney Trouble	
Arthritis	Cancer	Liver Trouble	
Glaucoma	Anemia	Blood Disorder	
Tuberculosis	Sinus Problems	Thyroid Trouble	
Gastrointestinal Diseases	Ulcers	Epilepsy	

Other: _____

15. Women: Are you pregnant? No_____Yes _____ Due Date: _____

DENTAL HISTORY:

16.	When was your last dental check-up? _____		
17.	Do you presently have a dental concern?_____	No	Yes
18.	Do you have or have had sensitive teeth, bleeding gums, bad breath or sore jaws?_____	No	Yes
19.	Do you feel nervous about having dental work done?_____	No	Yes
20.	Do you have dental implants? _____	No	Yes
21.	Have you experienced problems with dental treatment?_____	No	Yes

To the best of my knowledge, the above information is correct and I will advise the office of any future changes. I will give consent to be contacted via phone/email or text for appointment booking purposes.

Patient/Parent/Guardian Signature: _____

Date:_____