



PATIENT INFORMATION

Patient Name: _____ Date: _____

Male Female Gender diverse

Email: _____ Birthdate: day _____ mo _____ yr _____

Phone (Home): _____ (Work): _____ Cell: _____

Address:

Suite #: _____ Street: _____ City: _____

Province: _____ Postal Code: _____

Emergency contact:

Name: _____ Relationship: _____ Phone #: _____

HEALTH INFORMATION

Dental History

Date of last dental visit: _____ Reason for your last visit: _____

	Yes	No		Yes	No
Do your gums bleed when you floss?			Do you have earaches or neck pains?		
Are your teeth sensitive to hot, cold, sweets or pressure?			Do you have clicking or popping in your jaw?		
Is your mouth dry?			Do you brux or grind your teeth?		
Have you had any periodontal (gum) treatments?			Do you have sores or ulcers in your mouth?		
Have you ever had any orthodontic (braces) treatment?			Do you wear dentures or partials?		
Have you ever had any complications after dental treatment? Please explain:			Are you currently experiencing any dental pain or discomfort?		

What is the reason for your dental visit today?



How do you feel about your smile?

Medical History

Name of physician:

Phone number:

	Yes	No		Yes	No
Have there been any changes to your health within the last year? If yes, please explain:			Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, please explain:		

Have you ever had any of the following?

Allergies:			Jaundice		
Allergy/reaction to local anesthetics			Kidney disease		
Allergy/adverse reaction to aspirin			Liver disease		
Allergy/adverse reaction to penicillin or other antibiotics			Mental disorder		
Allergy/adverse reaction to codeine or other narcotics			Nervous disorder		
Allergy/adverse reaction to sulfa drugs			Osteoporosis		
Barbiturates, sedatives or sleeping pills			Pacemaker		
Seasonal (e.g. hayfever)			Radiation treatment		
Abnormal bleeding			Respiratory Problems (inc. asthma)		
Anaphylaxis			Rheumatic fever		
Anemia			Rheumatism		



Arthritis		Sinus problems		
Blood disease		Stomach problems		
Breathing or sleep problems (apnea)		Stroke		
Cancer		Thyroid problems		
Diabetes		Tuberculosis		
Dizziness		Tumours		
Epilepsy or seizures		Ulcers		
Excessive bleeding		Venereal disease		
Fainting		Do you use tobacco? <i>If yes, how often per week?</i>		
Glaucoma		If female:		
Heart disease		Pregnant If yes, number of weeks:		
Heart murmur		Birth control		
Hepatitis		Nursing		
High blood pressure		Other:		
HIV positive		Other:		
If you are currently taking any medications, please list them below.				
Do you have any disease, problem or condition not listed above? Please explain.				
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.				
Signature: _____		Date: _____		