# PATIENT INFORMATION FORM

NAME ______________________ DATE OF BIRTH ______________
Day Month Year

ADDRESS ______________________
Number & Street

______________________ HOME PHONE NO. ______________
City Postal Code

CELL PHONE NO. ______________ BUSINESS PHONE NO. ______________

EMAIL ADDRESS ______________________

PREFERED CONTACT METHOD: TEXT MESSAGE ☐ EMAIL ☐ PHONE ☐

EMPLOYER OR SCHOOL ______________________

IN AN EMERGENCY, PLEASE NOTIFY: ______________ PHONE ______________

PRESENT PHYSICIAN ______________ PHONE ______________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________

PREVIOUS DENTIST ______________ CITY ______________

PRIMARY INSURANCE COMPANY AND POLICY ______________

PRIMARY CERTIFICATE NO. ______________

SECONDARY INSURANCE COMPANY AND POLICY ______________

SECONDARY CERTIFICATE NO. ______________

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your permission.

## DENTAL HISTORY

| | | Yes | No |
|---|---|---|---|
| 1. | How long has it been since you last visited a dentist? ........................................ | | |
| 2. | Have you had regular dental care? ........................................ | ☐ | ☐ |
| 3. | Have you ever had teeth extracted? ........................................ | ☐ | ☐ |
| 4. | Any complications? ........................................ | ☐ | ☐ |
| 5. | Have you ever had any bad reactions to local or general anaesthetics? ................ | ☐ | ☐ |
| 6. | How often, do you brush your teeth? ........................................ | ☐ | ☐ |
| 7. | Do your gums bleed when you brush them? ........................................ | ☐ | ☐ |
| 8. | Do you use dental floss? ........................................ | ☐ | ☐ |

9. Describe, in your words, your present dental problem. ........................................
........................................................................................

10. Are you happy with the shape and colour of your teeth? What, if anything, would you like to improve your smile? ........................................

## MEDICAL HISTORY

| | | Yes | No |
|---|---|---|---|
| 1. | Are you in good health?........................................ | ☐ | ☐ |
| 2. | Are you presently under observations or treatment (medically or dentally) for any other complaint? ........................................ | ☐ | ☐ |
| 3. | Are you taking any drugs, either prescribed or self administered? ........................ | ☐ | ☐ |

(Please circle) tranquillizers diuretics heart pills birth control pills fosamax aspirins sleeping pills steroids analgesics vitamins actonel others:

Please specify names & dosages ........................................
........................................................................................

| | | Yes | No |
|---|---|---|---|
| 4. | Have you noticed any recent loss of energy or reduction in exercise tolerance? ......... | ☐ | ☐ |

| | | Yes | No |
|---|---|---|---|
| 5. | Have you noticed any recent change in appetite? | ❑ | ❑ |
| 6. | Are you on a special diet? | ❑ | ❑ |
| 7. | Has your weight been constant? | ❑ | ❑ |
| 8. | Do you have any decrease in tolerance to heat or cold? or, in other words, do you sweat excessively or feel chilled when no one else does? | ❑ | ❑ |
| 9. | Do you sleep well? | ❑ | ❑ |
| 10. | Do you have any tendency to bruise easily or bleed excessively? Which? | ❑ | ❑ |
| 11. | Have you experienced shortness of breath? | ❑ | ❑ |
| 12. | Do you have any allergies, such as to latex? Please specify | ❑ | ❑ |
| 13. | Have you ever had a reaction to a drug and been advised not to take it again? (eg. penicillin) | ❑ | ❑ |
| 14. | Women: Are you pregnant? | ❑ | ❑ |
| 15. | Do you smoke? How much? For how long? | ❑ | ❑ |
| 16. | Did you have any unusual childhood diseases? | ❑ | ❑ |

17. Do you have, or have you ever had? (Please circle)

| | | | |
|---|---|---|---|
| | | osteoporosis | multiple myeloma |
| heart trouble | epilepsy | blood disorder | HIV/AIDS |
| sexually transmitted disease | high blood pressure | thyroid trouble | diabetes |
| prosthetic heart valve | kidney trouble | tuberculosis | anaemia |
| asthma | liver trouble | prosthetic joints | arthritis |
| psychiatric Rx | cancer | any others - specify | |

| | | Yes | No |
|---|---|---|---|
| 18. | Any family history of any of the above? Specify | ❑ | ❑ |
| 19. | Have you ever been hospitalized? Specify | ❑ | ❑ |
| 20. | Have you ever had rheumatic fever or heart murmur? Specify | ❑ | ❑ |
| 21. | Have you ever had hepatitis? Which type? | ❑ | ❑ |
| 22. | Have you ever taken steroids? How long ago? | ❑ | ❑ |
| 23. | Have you ever had cardiac surgery? If yes, when? | ❑ | ❑ |
| 24. | Do you travel extensively to third world countries? | ❑ | ❑ |
| 25. | Have you ever had any other serious illness? | ❑ | ❑ |

## OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it will be necessary to charge for time lost.
Office policy is that services rendered in this office are the financial responsibility of the patient. Payment is due when services are rendered. Please indicate payment method you prefer to use:
Cash or cheque ❑ Visa ❑ Mastercard ❑ Interac ❑
Please discuss arrangements for payment with the receptionist.

## PATIENT (GUARDIAN) CONSENT & APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge. I have not omitted any pertinent information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated. I will assume responsibility for fees associated with these procedures.

Patient Signature
(or Parent or Guardian)________________________ Date____________