## Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

			Patient #
Deti and Information			SS#/SIN
Patient Informa	ation (CONFI	IDENTIAL)	Date
Name		Birthdate	Home Phone
Address		City	State/ Zip/ ProvP.C
Email			
Check Appropriate Box: ☐ Minor If Student, Name of School/College -	☐ Single ☐ Married	☐ Divorced ☐ Widowed ☐	Separated State/ Full Part
If Student, Name of School/College -		City	Prov. Time Time
Patient or Parent/Guardian's Employ	yer		Work Phone
Business Address		City	State/ Zip/ Prov. P. C.
Spouse or Parent/Guardian's Name		Employer	Work Phone
Whom may we thank for referring	you?		
Person to contact in case of emerge	ncy		Phone
Responsible Pa	rtv		
			Relationship to Patient
Name of Person Responsible for thi			
Address			
Email			Cell Phone
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Driver's License#			
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Physician		Office Phone				_ Date of Last Exam		
		Yes	No				Yes	ļ
. Are you under medical treatment now?	·	📙 🦈		10. Are you	u wearing	contact lenses?	Ш	L
Have you ever been hospitalized for an				11. Areyou	allergic to or	have you had any reactions to the following?		ſ
surgical operation or serious illness wit		5 years?		Local A	nesthetics	(e.g. Novocain)	H	
If yes, please explain						ther Antibiotics		l
				Sulja D	rugs		H	1
. Are you taking any medication(s)								
including non-prescription medicine?								
If yes, what medication(s) are you taki	ing?							
						ickel, mercury, etc.)		
. Have you ever taken Fen-Phen/Redux?	?			Later R	Rubber		П	
. Have you ever taken Fosamax, Boniva, A				Other (	please list)			
medications containing bisphosphonate	es?			12. Do you	have a persi	istent cough or throat clearing not		
. Have you taken Viagra, Revatio, Cialis						own illness (lasting more than 3 weeks)?		
in the last 24 hours?				13. Women		more time o mondy:		
. Do you use tobacco?						nt or think you may be pregnant?		
. Do you use controlled substances?	C 11					g?		
. Do you have or have you had any of th	e following?			c) Are v	ou taking	oral contraceptives?		
	Yes No			Ye		•	Yes	
High Blood Pressure		Heart Disease				Chest Pains		
Heart Attack		Cardiac Pacemake				Easily Winded		
Rheumatic Fever		Heart Murmur				Stroke		
Swollen Ankles		Angina				Hay Fever / Allergies		
Fainting / Seizures		Frequently Tired				Tuberculosis		
Asthma		Anemia				Radiation Therapy		
Low Blood Pressure		Emphysema				Glaucoma		
Epilepsy / Convulsions		Cancer				Recent Weight Loss		
Leukemia		Arthritis				Liver Disease		
Diabetes		Joint Replacement				Heart Trouble		
Kidney Diseases		Hepatitis / Jaundic				Respiratory Problems		
AIDS or HIV Infection		Sexually Transmitt	ted Dise	ase		Mitral Valve Prolapse		
Thyroid Problem		Stomach Troubles	/ Ulcers	E		Other		
	lictor	C)						
Patient Dental H		y						
ame of Previous Dentist and Locatior	n		N.T.			Date of Last Exam	Yes	1
D 11 1 1 1 1 1 1	0	Yes	No	0 D.	h £	out handaches?		[
Do your gums bleed while brushing or			H			ent headaches?		[
2. Are your teeth sensitive to hot or cold liquids/foods?			9. Do you clench or grind your teeth?					L
Are your teeth sensitive to sweet or so			H			ips or cheeks frequently?		L
Do you feel pain to any of your teeth?						l any difficult extractions		٢
Do you have any sores or lumps in or						1 1 111 1.		l
Have you had any head, neck or jaw				12. Have yo	ou ever had	l any prolonged bleeding		ſ
Have you ever experienced any of the fo	ollowing			followin	ig extraction	ons?orthodontic treatment?	H	1
problems in your jaw?				13. Have yo	ou had any	orthodontic treatment?		-
Clicking				14. Do you	wear dent	ures or partials?	Ш	l
Pain (joint, ear, side of face)			Ц	If yes, d	late of plac	ement		
Difficulty in opening or closing			Ц	15. Have yo	ou ever rec	eived oral hygiene instructions		,
Difficulty in chewing				regardir	ng the care	of your teeth and gums?	Ц	١
1 4 le agrice a ti age	nd D	aleace		16. Do you	like your	of your teeth and gums?smile?		١
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