

## PATIENT INFORMATION

Mrs. Miss Mr. Mstr.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City : \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Home Telephone # \_\_\_\_\_

Employer: \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Cell # \_\_\_\_\_

When is the best time to reach you: \_\_\_\_\_

And at which phone number: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Email Address: \_\_\_\_\_

Are you covered by a dental plan? Y N Sex: Female/ Male

How did you find out about our office? \_\_\_\_\_

## DENTAL HISTORY

When was your last visit to a dentist? \_\_\_\_\_ Dentist's name: \_\_\_\_\_

How long has it been since you went for a cleaning at a dentist? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss between your teeth? \_\_\_\_\_

Are you experiencing any problems with your teeth or gums at this time? \_\_\_\_\_

Are you satisfied with how your teeth look? \_\_\_\_\_

Do you suffer from any anxiety or phobia from dental treatment? Y N

Do you have any concerns or issues about dentistry that you want explained during your visit? \_\_\_\_\_

Is there anything the dentist or staff can do during your appointment to make your visit as enjoyable and pleasurable as possible? \_\_\_\_\_

How do you rate your smile between 1 and 10? \_\_\_\_\_

Are you interested in whitening your teeth? \_\_\_\_\_

### Medical History

Yes No 1. Are you currently suffering from major illness?

Yes No 2. Have you ever been hospitalized and what was the reason?

Yes No 3. Are you currently taking any prescription or non-prescription medication?

Yes No 4. Do you suffer from any allergies to medications or substances?

Yes No 5. Have you ever suffered from any physical problems during a dental visit?

Yes No 6. Are you currently or have you ever suffered from any of the following conditions?

\_\_\_ \_\_\_ Heart trouble, heart attack, or stroke

\_\_\_ \_\_\_ Rheumatic fever or heart murmur

\_\_\_ \_\_\_ Difficulty breathing

\_\_\_ \_\_\_ Chest pain

\_\_\_ \_\_\_ High blood pressure

\_\_\_ \_\_\_ Diabetes

\_\_\_ \_\_\_ Fits, Seizures, convulsions, or epilepsy

\_\_\_ \_\_\_ Kidney disease

\_\_\_ \_\_\_ Liver disease

\_\_\_ \_\_\_ Indigestion, heartburn, ulcer

\_\_\_ \_\_\_ Bleeding disorder

\_\_\_ \_\_\_ Do you smoke? If yes, how much? \_\_\_\_\_

Female:

\_\_\_ \_\_\_ Are you pregnant? If yes, what is your due date? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Additional

Notes: \_\_\_\_\_