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PLEASE COMPLETE THE FOLLOWING PERSONAL INFORMATION:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province/State: \_\_\_\_\_ Postal Code/Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Birthdate (DD/MM/YYYY): \_\_\_\_\_  Male  Female

Spouse or Guardian \_\_\_\_\_

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**LET OUR RECEPTIONIST HELP YOU WITH THIS PART**

DENTAL INSURANCE (PRIMARY CARRIER)

Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Employee: \_\_\_\_\_

Group#: \_\_\_\_\_

S.I.N.: \_\_\_\_\_

A) Basic                   %           B) Major                   %

C) Ortho                   %           D) Annual limit

DENTAL INSURANCE (SECONDARY CARRIER)

Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Employee: \_\_\_\_\_

S.I.N.: \_\_\_\_\_

A) Basic                   %           B) Major                   %

C) Ortho                   %           D) Annual limit

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

REFERAL INFORMATION

Is another member of your family a patient at our office? Please list:

\_\_\_\_\_

Referred to us by: \_\_\_\_\_

EMERGENCY INFORMATION

Emergency contact: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

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1. Are you feeling pain or discomfort at this time?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
2. Have you had a medical examination in the last year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
3. Do you feel very anxious about having dental treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4. Have you been a patient in the hospital during the past two years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
5. Physician's name: _____	phone: _____		
6. List any medication you are currently using:			
7. Are you taking Aspirin?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
8. Are you allergic or have you reacted adversely to any of the following medications? (please circle)			
Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	Novocain
Codeine	Tetracycline	Penicillin	Sleeping pills
Demerol	Percodan	Other Antibiotics	Nembutal/Seconal
9. Are you aware of being allergic to any other medications or substances?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
10. Circle any of the following which you have had or have at present:			
Allergies or Hives	Drug Addiction	Heart Disease or Attach	Cough
Anemia	Rheumatism	Fainting or Dizzy Spells	Angina Pectoris
Blood Transfusion	Scarlet Fever	Diabetes	Hemophilia
Bruise Easily	Chemotherapy	Any lung disease	Congenital Heart Lesions
Fever Blisters	High Blood pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice	Heart Pacemaker
Hepatitis A (infectious)	Heart Failure	Emphysema	A.I.D.S.
Kidney Trouble	Glaucoma	Ulcers	Pain in Jaw Joints
Sickle Cell Disease	Cosmetic Surgery	Rheumatic Fever	Sinus Trouble
Stroke	Cortisone Medicine	Nervousness	HIV +
Tuberculosis (TB)	Hepatitis B (serum)	Artificial Heart Valve	Thyroid Disease
Venereal Disease	Artificial Joints (hip/knee)	Arthritis	Epilepsy or Seizures
X-Ray or Cobalt Treat.	Cold Sores	Heart Surgery	Stomach Problems
11. Do you wish to speak privately to the Doctor about any medical condition?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
12. When walking up stairs or taking a walk, do you ever stop because of pain in your chest?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
13. Do our ankles swell during the day?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
14. Have you lost or gained more than 10 pounds in the past year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
15. Do you ever wake up from sleep short of breath?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
16. Are you on a special diet?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
17. Has your medical doctor ever said you have a cancer or tumor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
18. Do you have a tendency to faint?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
19. Do you have frequent severe headaches?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
20. Have you had a regular dental examination (annually) in the past?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
21. Do you have any disease, condition, or problem not listed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
22. Are you pregnant? (Women only)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, what month?

### CONSENT

The undersigned hereby authorizes Doctor, upon consultation and direct consent from patient to take X-rays, study models, photographs, or any other diagnostics aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) \_\_\_\_\_ further to my consultation and direct consent. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements including insurance or otherwise, have been made.

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

Date (DD/MM/YYYY): \_\_\_\_\_