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WELCOME TO OUR CLINIC! The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please complete the entire form.

Date: *DD* / *MM* / *YYYY* (for office use only) **Medical Alerts:** _____

PERSONAL INFORMATION

Patient Name: _____ Gender: M/F Date of Birth: *DD* / *MM* / *YYYY* Age:_____

Address: _____

Postal Code:_____City:_____

Email Address: _____ Best Contact Number: _____

Emergency contact:_____ Phone:_____

Medical Doctor:_____ Phone:_____

Specialist Name:_____ Phone:_____

Pharmacy Name: _____Phone:_____ Fax:_____

Insurance Benefit name: _____

Subscriber Name/Birthdate:_____*DD* / *MM* / *YYYY* Policy:_____ID:_____

Secondary Ins Company Name: _____

Subscriber Name/Birthdate:_____*DD* / *MM* / *YYYY* Policy: _____ID:_____

Subscriber's Address if diff. from above:_____

Who may we thank for referring you? _____

OFFICE POLICY: Your appointment is reserved especially for you. **If you are unable to keep the appointment, we will require 48 hours notice otherwise it may be necessary to charge for the lost time**.

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor, insurance provider or pharmacist may be required and authorize the dentist and his staff to do so. I understand that payment for all dental services is my responsibility even if I have insurance benefits.

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MEDICAL HISTORY

Have you ever had a serious illness requiring hospitalization or extensive medical care? o Yes o No

If yes, please explain:

_____

_____

When was your last medical checkup?

_____

Any change in your general health? o Yes o No If yes, please explain:

_____

Do you have any allergies? If you answer yes, please list using the categories below: o Yes o No

a. Medications:

_____

b. Other: (ie. Hay fever, foods):

_____

Are you taking any medication, non-prescription drugs, or herbal supplements of any kind? o Yes o No

If yes, please list. (ie. birth control pills, vitamins, homeopathic, warfarin, aspirin)

Medication	Frequency	Dose	Condition it treats

Have you ever had a peculiar reaction to any medicine or injection? o Yes o No

If yes, please explain:

_____

Do you or have you ever had problems with any of the following? Please check all that apply:

Stroke	Diabetes	Liver Disease
Kidney Disease	Drug/Alcohol dependency	High/Low Blood Pressure
Osteoporosis/Bone Caner	Sinus/Middle ear problems	Prosthetic/ Artificial joint
Rheumatic Fever	Cancer	Epilepsy/Seizures
Heart Murmur	Pacemaker	Mental Health
Thyroid Disease	Asthma/Lung Disease	Glaucoma/Vision problems
Tuberculosis	Blood clotting/Abnormal bleeding	Hepatitis A, B or C
Arthritis/ Rheumatism	Heart Valve repair	Surgery (please explain)

Are there any conditions or diseases not listed that you have now or had in the past? o Yes o No
If yes, please list:

_____

_____

Are there any diseases or medical conditions that run in your family? (ie. cancer, heart disease, etc.) o Yes o No
If yes, please list below:

_____

Do you smoke, vape or chew tobacco products? o Yes o No If yes, Frequency? _____

Are you pregnant or breast feeding? o Yes o No

DENTAL HISTORY

How frequently do you see a dentist or hygienist? o 6 months o Yearly o Other:_____

When was your last dental visit?_____ **Last X-Rays?** _____

Name of your last dentist?_____ **Office Name**: _____

How often do you brush your teeth?_____ **Floss?** _____

Are your teeth sensitive to:_____ o Hot o Cold o Sweets o Chewing

Do your gums bleed when:_____ o Brushing o Flossing o Never

Do your gums feel swollen and tender?_____ o Yes o No

Do you feel you have bad breath or bad taste in mouth?_____ o Yes o No

Does your jaw pop or crack when opening widely?_____ o Yes o No

Do you grind or clench your teeth?_____ o Yes o No

Do you have food catch between your teeth?_____ o Yes o No

Have you ever had any problems with previous dental treatments?_____ o Yes o No

Are you satisfied with your teeth?_____ o Yes o No

Have you been diagnosed with sleep apnea?_____ o Yes o No

Do you have any specific requests to make your visits more comfortable?

_____

Would you like to discuss any of the following?

o Orthodontics/Invisalign o Cosmetic Dentistry o Gum Graft treatment

o Whitening o Implants o Migraines & Botox Treatment

Is there anything else you would like to mention to the dentist that has not been covered on this form?

_____

_____

To the best of my knowledge, the above information is correct.

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature:_____ Date:_____