Patient Information

Name (Last, First): ____ DOB (DD/MM/YY):____/____/___

Address: ____

City: _____________________________ Province: _____________

Phone (H): ____________________ (W): _____________________ (C): _____________________

Emergency Contact: ______________________________________ Relationship: _________________

Insurance Information

Name of Subscriber: __________________________________ DOB (DD/MM/YY): _____ /_____ /____

Patient's Relationship to Subscriber: __________________________________

Name of Employer: ____

Insurance Company: ____

Group/Policy Number: ______________________ Certificate/ID Number: ________________

Who may we thank for referring you? ☐ Patient: _____________________________

☐ Google ☐ Facebook ☐ Building/Office Signage ☐ Other

Dental History

Previous Dentist? ____

Have you had regular dental examinations (annually) ☐ Yes ☐ No X-rays? ☐ Yes ☐ No

Do you have any currently problems? ____

Are you satisfied with your smile? ☐ Yes ☐ No, interested in the following:

☐ Whitening ☐ Orthodontics ☐ Veneers/Crowns ☐ Replace missing teeth

Continued on the back ⟶

Medical History

Personal Physician: ______________________________ Phone: ________________________

ALLERGIES: ☐ No ☐ Yes, please list: ____

Have you been advised that you require premedication prior to dental treatment?

☐ Yes, _____________________ ☐ No, ________________________

Have you ever had any of the following diseases or conditions? Please check off all that apply

	HIV		Cancer		Hepatitis
	Asthma		Diabetes		Herpes
	Anaemia		Epilepsy		Kidney Problems
	Angina		Endocrine Problems		Liver Problems
	Blood Disease		Emotional Problems		Pulmonary (Lungs)
	High Blood Pressure		Heart Disease		Rheumatic Fever
	Low Blood Pressure		Hearing Disorder		Thyroid
	Bone Disorder		Head or Face Injury		Venereal Disease

Have you ever been hospitalized for any of the above health issues? Yes ☐ No ☐

Are under the care of a physician? ____

Are you taking any drug or medicine presently? _______________________________________

Do you have any pain or soreness around your eyes, ears, or parts of your face? ____________

Does your jaw click or pop when you yawn or eat? ____________________________________

Do you have 'Tension Headaches', Stiff Neck Muscles? _________________________________

Do you clench your teeth while sleeping? ____

Do your jaw muscles ever feel tired? ____

I hereby certify that the Dental and Medical History is accurate and complete to the best of my knowledge. I consent to the performing and oral surgery procedures agreed to be necessary or advisable. I will assume responsibility for fees associated with those procedures.

Signature: ___________________________________ Date: _________________________