

Personal Data

First Name		Last Name					
Address		Apt.					
City	Province	Postal Code					
Date of Birth [D/M/Y]	Date of Birth [D/M/Y]						
Home Phone		Business Phone					
Occupation		Company					
Referred by	Person responsible for account	it: Self Other					
Dental Insurance: No ☐ Yes ☐ Insurance Name							
S.I.N.		Group (Policy) No.					
Physician Name		Telephone	Telephone				
In case of emergency please no	otify: Name						
Relationship		Telephone					
Dental History 1. Have you ever had a complete dental examination with a full series of x-rays of your teeth Yes □ No □							
and jaw?							
2. When was your last dental visit?							
3. What was done at that visit?							
4. Name of last dentist?							
5. Have you ever had local an	Yes No						
Any complications:							
6. Are any of your teeth sensitive to: Cold ☐ Sweets ☐ Heat ☐ Other ☐							
7. Do your gums bleen when: Brushing ☐ Flossing ☐ Spontaneously ☐							
8. Do your gums feel swollen or tender?			Yes □ No □				
9. Do you catch food between your teeth?			Yes □ No □				
10. Does your jaw crack, pop or grate when you open widely?			Yes □ No □				
11. Do you grind or clench your teeth?			Yes □ No □				
Dental Update:							



Health Questionnaire

Are you in good health? Yes □ No □			Are you presently under the care of a physician? Yes \(\Bar{\cup} \) No \(\Bar{\cup} \)					
If so, for what?								
When was your last med	dical examination?							
When were you last adm	nitted to hospital?							
Are you taking any med	Are you taking any medication? Yes □ No □ If so, what?							
Are you allergic to penicillin? Yes □ No □			Are you allergic to any other drug? Yes □ No □					
If so, for what?								
Are you a smoker? Yes □ No □			Do you drink alcohol? Yes □ No □					
Has your physician ever told you to have antibiotics prior to dental procedures? Yes □ No □								
Have you ever had any complications following a medical or dental procedure? Yes □ No □								
FOR WOMEN ONLY: Do you take birth control pills? Yes \(\square\) No			☐ Are you pregnant? Yes ☐ No ☐					
Please check all that apply								
chest pain	Yes 🗆 No 🗆	swellin	ng of ankles	Ye	es 🗆	No 🗆	tendency to bruise easily	Yes □ No □
sleeplessness	Yes 🗆 No 🗆	shortn	ess of breath	Ye	es 🗆	No 🗆	difficulty breathing at night	Yes □ No □
weight loss	Yes 🗆 No 🗆	loss of	appetite	Ye	es 🗆	No 🗆	low tolerance to hot / cold	Yes □ No □
persistent cough	Yes □ No □	excess	ive fatigue	Ye	es 🗆	No 🗆	reduced exercise tolerance	Yes □ No □



Do you now, or have you ever had the following?

heart attack	Yes □ No □	heart disease	Yes 🗆	No 🗆	rheumatic fever	Yes □ No □	
heart murmur	Yes □ No □	pace maker	Yes 🗆	No 🗆	bleeding problems	Yes □ No □	
epilepsy	Yes □ No □	stroke	Yes 🗆	No 🗆	severe headaches	Yes □ No □	
glaucoma	Yes □ No □	deafness	Yes 🗆	No 🗆	nervous breakdown	Yes □ No □	
hay fever	Yes □ No □	asthma	Yes 🗆	No 🗆	sinus trouble	Yes □ No □	
allergies	Yes □ No □	skin rash	Yes 🗆	No 🗆	frequent colds	Yes □ No □	
emphysema	Yes □ No □	tuberculosis	Yes 🗆	No 🗆	lung disease	Yes □ No □	
ulcers	Yes □ No □	diabetes	Yes 🗆	No 🗆	kidney trouble	Yes □ No □	
arthritis	Yes □ No □	steroids	Yes 🗆	No 🗆	hip replacement	Yes □ No □	
cancer	Yes □ No □	radiation	Yes 🗆	No 🗆	chemotherapy	Yes □ No □	
jaundice	Yes □ No □	hepatitis	Yes 🗆	No 🗆	venereal disease	Yes □ No □	
neualgia	Yes 🗆 No 🗆	major surgery	Yes 🗆	No 🗆	serious accident	Yes □ No □	
heart valve replacement	Yes 🗆 No 🗆	immune defiency disease	Yes 🗆	No 🗆	other joint replacement	Yes 🗆 No 🗆	
mitral vale prolapse	Yes □ No □	thyroid disease	Yes 🗆	No 🗆	anemia or blood disorder	Yes □ No □	
high blood pressure	Yes □ No □	gastrointestinal disease	Yes 🗆	No 🗆	facial or jaw surgery	Yes □ No □	
fainting or dizzy spells	Yes □ No □	arterio-venous shunt	Yes □ No □		other serious illness	Yes 🗆 No 🗆	
Signature of Patient				Date			
Please note: To avoid a cancellation fee - 48 Hour Notice is Required							
Signature of Patient					Date		
Medical Update							