Personal Information

First Name		Last Name		Preferred Name	
Birthday (mm/dd/yyyy)		Age		Adult	Child
Address					
City		Province		Postal Code	
Home Phone		Cell Phone		Email	

How may we contact you? Phone call Text Message Email

In case of emergency who should we call? Name: Phone:

Please check any that apply:

Anemia	Emphysema	Head / Neck Injury	Rheumatic Fever
Angina	Epilepsy / Seizures	Herpes	STD's, HIV, AIDS
Asthma / Hay Fever	Fainting / Dizziness	Jaundice	Sickle Cell
Arthritis	Glandular Disorder	Kidney Disease	Stroke
Bronchitis	Glaucoma	Liver Disease	Sinus Problems
Blood Disorders	Heart Attack	Lung Disease	Strep Throat
Bowel Disease	Headaches / Migraines	Low Blood Pressure	Scarlet Fever
Cancer	Hearing Impairment	Lupus	Snoring / Sleep Apnea
Chrome's Disease	Heart Murmur	Lyme Disease	Tumor / Growth
Cortisone / Steroids	Heart Pacemaker	Mental Disorders	Thyroid Disease
Chronic Dry Mouth	Heart Palpitations	Mitral Valve Prolapse	Tuberculosis
Circulatory Problems	Valve Replacement	Medical Implant	Tonsillitis
Diabetes	Hepatitis -	Organ Transplant	Ulcers
Depression	High Blood Pressure	Osteoporosis	
Digestive Problems	Hodgkin's Disease	Psychiatric Treatment	
Endocrine Disorders	Hypertension	Radiation Therapy	NONE

Female Patients

Is there a chance you could be pregnant? Yes No If yes, when is your due date?

Are you currently nursing? Yes No

Are you currently on any form of birth control? Yes No

Are you currently taking hormones? Yes No

Adolescent Patients

Are all vaccinations up to date? Yes No

Has the child had any of the following? Measles Mumps Chickenpox

Medical information and History

Question		
Have you ever been advised to take antibiotics before dental appointments?	Yes	No
Are you currently being treated for any medical condition at present or within the past 2 years?	Yes	No
Do you have frequent severe headaches, earaches, ear / throat infections?	Yes	No
Have you ever had an operation or surgery of any kind?	Yes	No
If so, what was it and when?		
Have you ever reacted adversely to or have been told not to take any medications or injection?	Yes	No
If so, what was it and when?		
Are you taking any prescription or non-prescription medication including herbal remedies or vitamins?	Yes	No
If so, please list all:		

Question					
Do you use recreational drugs?	Yes	No			
Do you drink alcohol?	Yes	No	Daily	Weekly	Occasionally
Do you smoke tobacco or marijuana?	Yes	No	Daily	Weekly	Occasionally

Please list allergies:

Dental History

Date of your - Last dental visit: Last dental hygiene: Last x-rays:

Is there a dental problem you would like treated immediately? Yes No If so, please explain?

I brush	Never	Occasionally	Weekly	Daily	More than once daily
I floss	Never	Occasionally	Weekly	Daily	More than once daily

General:

Question		
Have you been seeing a dentist regularly?	Yes	No
Are any of your teeth sensitive to hot or cold?	Yes	No
Do you feel that you have bad breath?	Yes	No
Do your gums bleed when brushing or flossing?	Yes	No
Do you wear a night guard?	Yes	No
Have you ever had braces or Invisalign?	Yes	No
Does food catch between your teeth?	Yes	No

In association with your jaw,

Question		
Do you experience tired jaw or pain when chewing or have difficulty opening or closing?	Yes	No
Do you hear popping or clicking when you open or do you experience pain in your jaw, ears or face?	Yes	No
Have you ever been treated for TMJ (jaw joint) problems?	Yes	No
Do you have any trauma to your head, neck or jaw (even in early childhood)?	Yes	No

Oral habits:

Question		
Do you clench or grind your teeth when awake or asleep or mouth breath while awake or asleep?	Yes	No
Do you chew gum or bite your cheeks or lips or place pens, paperclips, fingernails etc. in your mouth?	Yes	No
Do you drink more than one cup of coffee a day or consume sweets, pop and / or add sugar in your coffee?	Yes	No

have you ever been told that you gasp for air in your sleep or been diagnosed with sleep apnea? Yes No

Do you expect to wear dentures someday? Yes No

Are you missing teeth? Yes No If so, why?

Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information we collect use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- This also includes information for pre-determination of benefits to insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment via email and text.
- To send patients informational material about our dental practice.

Patient's Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment on all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to other health care professional for either a second opinion or treatment.

I, the undersigned, certify that to the best of my knowledge all the information I have provided today is correct. I have not knowingly omitted any information. I have had the opportunity to ask questions and received answers regarding my medical & dental history. Should there be any change in either my health status or personal information I have provided I will advise the office. I understand that all information is collected in strict confidence and is solely used to improve communications between this office and myself. **I authorize the dental staff to perform such dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company for legal documentation.**

I have read the above conditions of treatment and agree to their content. **Date:** / /
DD MM YYYY

Print name **Signature** **Relationship (Parent)**