

**CONTACT INFORMATION AND MEDICAL HISTORY FORM**

**PERSONAL INFORMATION: PATIENT**

(Circle) Dr. Mr Mrs. Miss. Ms.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ AHC #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**IF PATIENT IS A CHILD**

Father's Name: \_\_\_\_\_

Father's Address: \_\_\_\_\_ City: \_\_\_\_\_

Father's Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Address: \_\_\_\_\_ City: \_\_\_\_\_

Mother's Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**ACCOUNT INFORMATION**

**PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT**

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

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

FINANCIAL RESPONSIBILITY

I understand that I am responsible for fees associated with treatment performed including those not covered by my dental plan, if any. Payment is due on day of service unless other arrangements have been made.

Patient's (Parent's) Signature \_\_\_\_\_ Date: \_\_\_\_\_

DENTAL HISTORY: To help us understand past dentistry, tell us about your experiences:

1. Last visit: \_\_\_\_\_ 2. Last Hygiene: \_\_\_\_\_ 3. Radiographs: \_\_\_\_\_

4. Have you experienced: \_\_\_ Orthodontics \_\_\_ Periodontal (Gum) Treatment \_\_\_ Extractions  
\_\_\_ Root Canal Treatment \_\_\_ Crowns \_\_\_ Bridges \_\_\_ Veneers \_\_\_ Implants \_\_\_ Dentures

- 5. Do you suffer from headaches?..... YES NO
6. Are you aware if you grind or clench your teeth?..... YES NO
7. Have you noticed any teeth becoming loose?..... YES NO
8. Do you have any teeth with sensitivity to ( )hot, ( )cold, ( )sweet, ( )pressure?..... YES NO
9. Do you get food caught between your teeth?..... YES NO
10. Is there often bleeding when you floss?..... YES NO
11. How do you feel about your smile?..... YES NO
12. How would you rate your smile?..... YES NO
13. Is there anything you would like to change about your smile?..... YES NO
14. What is most important to you about your dental health, please number 1-4 in order of priority:
\_\_\_ aesthetics \_\_\_ comfort \_\_\_ function \_\_\_ longevity
15. What is the primary concern for today's visit? \_\_\_\_\_

MEDICAL HISTORY: Some Medications and health conditions can affect oral health and complicate dentistry. A medical history is very important.

- 1. Are you generally in good health now?..... YES NO
2. When was your last medical examination? \_\_\_\_\_ YES NO
3. Do you take any medication on a regular basis, including non-prescription? YES NO
Name and Dosage: \_\_\_\_\_
4. (Women) Have you reason to believe you are pregnant?..... YES NO

5. Do you have allergies to medication or anesthetic that you are aware of?.....   
Explain: \_\_\_\_\_

6. Have you had to take antibiotics prior to any dental treatment?.....   
Reason: \_\_\_\_\_

7. Have you had heart surgery involving the heart valves or pacemaker?.....

8. Do you have a heart murmur?.....

9. Have you had rheumatic fever?.....

10. Do you have ( ) high ( ) low blood pressure?.....

11. Have you had a stroke?.....

12. Do you have diabetes?.....

13. Do you suffer from excessive thirst / urination or frequent dry mouth?.....

14. Do you have epilepsy?.....

15. Do you have difficulties with clotting?.....

16. Do you have respiratory concerns such as asthma? (ventilator / inhaler) TB?\_\_\_.....

17. Do you use any tobacco products?.....

18. Have you had surgery for tumors, transplants or joint replacements?.....

19. Do you have chronic cold sores or canker sores?.....

20. Have you had: Hepatitis or HIV?.....

21. Is there anything else you feel we need to know about your medical health that may    
affect your treatment?

Explain: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

CONSENT FOR TREATMENT
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I consent to the performing of dental procedures agreed to be necessary or advisable.

I consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependants dental care.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date