

Patient Name: _____ Date: _____

DOB (DD/MM/YY): _____

Home Address: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Employer: _____ Occupation: _____

Email Address: _____

Spouse/Partner Name, if applicable: _____

Employer: _____ Occupation: _____

Approx. date of last dental visit? _____

Procedure done at that visit? _____

Have you had any recent dental X-rays? _____

Any current dental problems? _____

Any current dental discomfort or pain? _____

Name of person or office, if any, who referred you? _____

Who is responsible for payment of this account? _____

Do you, or your spouse, or both have dental insurance? _____

If yes, please fill in the following section completely.

INSURANCE INFORMATION

Primary Coverage

Name of insured: _____

Is insured person a patient here? _____ Insured's DOB: _____

Insurance plan name: _____

Group#: _____ ID#: _____ %covered: _____

Insured's employer's name: _____ Phone#: _____

Patient's relationship to insured Self? Spouse? Child? Other?

Secondary Coverage

Name of insured: _____

Is insured person a patient here? _____ Insured's DOB: _____

Insurance plan name: _____

Group#: _____ ID#: _____ %covered: _____

Insured's employer's name: _____ Phone#: _____

Patient's relationship to insured Self? Spouse? Child? Other?

Do you have or have you had any of the following? (please check off those that apply to you)

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental illness/Mood disorder |
| <input type="checkbox"/> Total joint replacement | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Alzheimer's/Dementia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Brain injury |
| <input type="checkbox"/> Excessive bleeding/bruising | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Faint/Seizures/Epilepsy | <input type="checkbox"/> Pregnancy: Due date: _____ |
| <input type="checkbox"/> Congenital heart disease/Heart attack/Stroke | <input type="checkbox"/> Respiratory problems/COPD/Asthma |
| <input type="checkbox"/> Heart surgery/Prosthetic valve | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sensitivity to latex |
| <input type="checkbox"/> Diabetes | Drug allergies (circle): penicillin, codeine, |
| <input type="checkbox"/> Hepatitis/Jaundice/Liver disease | Anaesthetics, other: _____ |
| <input type="checkbox"/> Kidney Disease | Allergies (general), to: _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> Radiation treatment | Anything not listed |

Do you take?

- Immuno-suppressive drugs
 Anticoagulants/Blood thinners/Aspirin
 Naturopathic remedies

Has there been any problems with your general health in the past 5 years? Yes No

If yes, please explain _____

Are you presently under any physicians care? Yes No

If yes, please explain _____

Name of Physician: _____ Phone# or city: _____

Are you presently taking any medications? (Please list)

Do you smoke? Yes No

Have you ever had any complications following dental treatment? Yes No

Do you have any health issues or problems that need further clarification, or anything else that you think the doctor should know about? Yes No

To the best of my knowledge, this information is complete and correct. If I ever have a change in my health, I will inform the doctors at the next dental appointment.

Signature of patient _____ **Today's date** _____