

<b>WELCOME TO OUR OFFICE</b>			<b>Account Number</b>
<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>INITIALS</b>	<b>DATE OF BIRTH</b> Y    /M    /D
<b>ADDRESS</b>			
<b>CITY/PROVINCE</b>			<b>POSTAL CODE</b>
<b>TELEPHONE</b>			
<b>RESIDENCE</b>		<b>BUSINESS</b>	<b>MESSAGE</b>
<b>OCCUPATION</b>		<b>EMPLOYER</b>	
<b>WHO MAY WE THANK FOR REFERRING YOU?</b>		<b>CARE CARD NUMBER</b>	
<b>PERSON RESPONSIBLE FOR ACCOUNT</b>	<b>SOCIAL INSURANCE NO.</b>	<b>DO YOU HAVE DENTAL INSURANCE?</b>	

### PRIMARY DENTAL INSURANCE

### SECONDARY DENTAL INSURANCE

<b>NAME OF INSURER</b>	<b>DATE OF BIRTH</b> Y    /M    /D	<b>NAME OF INSURER</b>	<b>DATE OF BIRTH</b> Y    /M    /D
<b>EMPLOYER</b>		<b>EMPLOYER</b>	
<b>INSURANCE CARRIER</b>		<b>INSURANCE CARRIER</b>	
<b>GROUP/POLICY NUMBER</b>	<b>DIVISION</b>	<b>GROUP/POLICY NUMBER</b>	<b>DIVISION</b>
<b>I.D. NUMBER OR S.I.N.</b>		<b>I.D. NUMBER OR S.I.N.</b>	
<b>CERTIFICATE NUMBER</b> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		<b>CERTIFICATE NUMBER</b> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>	
<b>LIMITS</b> BASIC <input type="checkbox"/> MAJOR <input type="checkbox"/> ORTHO <input type="checkbox"/>		<b>LIMITS</b> BASIC <input type="checkbox"/> MAJOR <input type="checkbox"/> ORTHO <input type="checkbox"/>	
<b>DEDUCTIBLE</b> BASIC <input type="checkbox"/> MAJOR <input type="checkbox"/> <input type="checkbox"/> PER PERSON <input type="checkbox"/> PER FAMILY		<b>DEDUCTIBLE</b> BASIC <input type="checkbox"/> MAJOR <input type="checkbox"/> <input type="checkbox"/> PER PERSON <input type="checkbox"/> PER FAMILY	

## HEALTH QUESTIONNAIRE

To help ensure your well being while receiving treatment in our office, please answer the following questions. All information will be considered confidential and for our records only.

1. Have you been examined and/or treated by a physician within the last year? Physician's Name: _____ Physician's Phone: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever been seriously ill or hospitalized?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Are you taking any medications or non-prescription drugs now? What? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please check  if you have or have had any of the following?

### SPECIFIC

- Rheumatic fever
- Heart murmur
- Congenital heart condition
- Heart attack
- Asteriosclerosis
- Stroke
- Angina pectoris
- Blood pressure problems
- Heart troubles
- Lung/breathing problems
- Kidney/bladder problems
- Stomach/intestinal problems
- Hepatitis/jaundice
- Diabetes
- Blood disorders
- Pacemaker/artificial valves
- Artificial joints/implants
- Infectious/communicable diseases

- Venereal disease
- AIDS
- Positive testing for HIV virus
- Tumors or growths
- Nervous/mental problems
- Epilepsy
- Thyroid disease
- Arthritis
- Inflammatory rheumatism
- Cortisone/steroid therapy

### SENSITIVITIES/ALLERGIES:

- Hepatitis/jaundice
- Diabetes
- Blood disorders
- Pacemaker/artificial valves
- Artificial joints/implants

### SYSTEMS REVIEW

- Prolonged bleeding after injury
- Bruise easily
- High risk group for AIDS
- Severe headaches
- Sinus trouble
- Sore throats
- Earaches
- Trouble hearing
- Shortness of breath
- Chest pains
- Swollen ankles
- Heart palpitations
- Extra pillows for sleep
- Persistent cough
- Blood in sputum
- Recent change of appetite
- Foods that you cannot eat
- Difficulty in swallowing

- Frequently indigestion/vomiting
- Feel thirsty much of the time
- Urinate more than 6 times/day
- Painful, swollen joints
- Numb/prickling sensations
- History of broken bones
- Tendency to faint
- Fits, seizures or convulsions
- History of family disease

### HABITS

- Tobacco
- Alcoholic beverages
- Non-prescription drugs
- Other

### WOMEN ONLY: Are you

- Pregnant (how many months \_\_\_)
- Past menopause

Have you ever been seriously ill or hospitalized? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
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Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Patient  Parent  Guardian

NOTES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### DENTAL HISTORY

1. Date of last dental visit: _____ Former Dentist: _____	
Purpose: _____	
2. Have you had regular dental care (annually) in the past?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Do you have any oral habits such as clenching, grinding your teeth, or nail biting?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Have you ever had tooth brushing instructions? How often do you brush your teeth? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever had instructions in using dental floss? How often do you floss your teeth? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Are you satisfied with the function and appearance of your teeth?	<input type="checkbox"/> YES <input type="checkbox"/> NO

7. Have you ever had or do you now have any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bridges             | <input type="checkbox"/> Extractions                    | <input type="checkbox"/> Gum treatments         |
| <input type="checkbox"/> Partial dentures    | <input type="checkbox"/> Loose teeth                    | <input type="checkbox"/> Surgery in your mouth  |
| <input type="checkbox"/> Full dentures       | <input type="checkbox"/> Orthodontic treatment          | <input type="checkbox"/> Sensitive teeth        |
| <input type="checkbox"/> Root canal fillings | <input type="checkbox"/> Swelling in your mouth or jaws | <input type="checkbox"/> Bleeding gums          |
| <input type="checkbox"/> Lost fillings       | <input type="checkbox"/> Injuries to your face or jaws  | <input type="checkbox"/> Sore or lumps in mouth |

8. What dental condition concerns you now? \_\_\_\_\_  
\_\_\_\_\_

### DENTAL HISTORY

I, the undersigned, consent to the dental treatment agreed upon and that I am responsible for payment of the corresponding fees. I understand that a possibility of complications exist for each treatment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Patient  Parent  Guardian