ADULT PATIENT INFORMATION

DATE _____

* Your co-operation in filling out the data on this confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with his office.

NAME (Dr. Mr. Mrs. Ms.) _____ (First / Middle / Last)

AGE _____ SEX _____ MARITAL STATUS _____ DATE OF BIRTH _____ (Day Mo Year)

ADDRESS _____ (Street / City / Prov. (State) / Postal Code (Zip))

HOMEPHONE _____ CELL _____

OCCUPATION _____ EMPLOYED BY _____

BUS. PHONE _____ EMAIL _____

DENTAL INS. YES NO NAME OF COMPANY _____

INS. POLICY No. _____ % ID # _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY NOTIFY: NAME _____

ADDRESS _____

RELATIONSHIP _____ TELEPHONE _____

OFFICE POLICY

Your appointment time will be reserved for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for time lost.

Payment is required on date of service.

CONFIDENTIAL MEDICAL HISTORY

1. Are you presently under the care of a physician?	YES	NO
Please specify _____		
2. Are you presently taking pills, drugs or medication?	YES	NO
Please specify _____		
3. Have you taken any prolonged medication in the past?		
Prescription or Non-Prescription	YES	NO
Please specify _____		
4. Have you had Rheumatic fever?	YES	NO
5. Do you have mitral valve prolapse?	YES	NO
6. Have you heart disease or murmur?	YES	NO
7. Have you had abnormal bleeding?	YES	NO
8. Have you taken cortisone or steroids?	YES	NO
9. Have you any allergies?	YES	NO
10. Have you allergies to any drugs, medicines or food?		
ie. Penicillin. Please specify _____	YES	NO
11. Have you ever been hospitalized and was surgery performed?	YES	NO
Please specify _____		
12. Have you ever had radiation or X-ray therapy?	YES	NO
13. Do you have any artificial joint replacement? _____	YES	NO
ie. Hips or knees.		

(Over)

14. Do you have or have you had?

High Blood Pressure	Anemia	Herpes	Sinus Problems
Low Blood Pressure	Arthritis	Cancer	Stroke
Nervous Problems	Epilepsy	Psychiatric Care	Tuberculosis
Thyroid Problems	Diabetes	Venereal Disease	Ulcer
Blood Disorders	Liver Trouble	Scarlet Fever	Fainting Spells
Heart Trouble	Hepatitis	Asthma	Kidney Trouble
Chest Pain	AIDS		

15. Are you currently in good health? ..... YES NO
16. Is there anything else you think you should tell me? ..... YES NO
    Please specify _____

FOR WOMEN ONLY

17. Are you pregnant? If so, what month? ..... YES NO

DENTAL HISTORY

1. Are you having any discomfort at this time? ..... YES NO
   Please specify _____
2. How long since your last dental visit? _____
   _____
3. What was done at that time? _____ YES NO
4. Do your gums feel tender or swollen? ..... YES NO
5. Have you ever been given local anaesthetic (freezing)? ..... YES NO
   Have you ever been given general anaesthetic? ..... YES NO
6. Any complications with #5? .....
   Please specify _____ YES NO
7. Are you aware of any lump or swelling in your mouth? ..... YES NO
8. Are you satisfied with the appearance of your teeth? ..... YES NO
9. Are you anxious to keep your natural teeth? ..... YES NO
10. Are you tense during dental visits? .....

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of dental procedures agreed to be necessary or advisable including the use of general anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parents) Signature _____ Date _____