CHURCH STREET Dental

Today's date: _____

Patient Information (all information is strictly confidential and will remain with this office)

Name: _____
Last First Prefer to be called

Address: _____
Street City Prov Postal Code

Telephone: _____
Home Work Cell

Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Month / day / year

Employed by: _____ Occupation: _____

How did you hear about our office? ___ Facebook ___ Google ___ Yellow Pages ___ Friend/Family ___ Blog ___ Existing Patients

Medical Information

Medical doctor: _____ Telephone: _____
Date of last physical exam: _____ Do you consider yourself to be in good health: _____
Are you presently under the care of a medical doctor: ___ Yes ___ No If yes please specify _____
Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins:
_____
Do you have any allergies or have you had any reaction to (medications, anesthetics, metals, latex, antibiotics, pain killers, dairy, etc.): _____
Do you have to take antibiotics prior to dental work? If yes, why? _____
Have you had heart surgery? If yes, please specify: _____
Do you have any artificial prosthesis (Joints, heart valve, etc)? If yes please specify: _____
Do you have abnormal bleeding? ___ Yes ___ No Do you become breathless easily? ___ Yes ___ No

Do you have or have had any of the following:

High blood pressure	____ Yes ____ No	Glaucoma	____ Yes ____ No	Heart murmur	____ Yes ____ No
Digestive disorders	____ Yes ____ No	Diabetes	____ Yes ____ No	Emphysema	____ Yes ____ No
Sinus problems	____ Yes ____ No	Cancer	____ Yes ____ No	Psychiatric care	____ Yes ____ No
Low blood pressure	____ Yes ____ No	Heart trouble	____ Yes ____ No	**Hiv/aids**	____ Yes ____ No
Head or Neck injuries	____ Yes ____ No	Kidney trouble	____ Yes ____ No	Osteoporosis	____ Yes ____ No
Venereal Disease	____ Yes ____ No	Ulcer	____ Yes ____ No	Anemia	____ Yes ____ No
Nervous problems	____ Yes ____ No	Hepatitis type	____ Yes ____ No	Thyroid disease	____ Yes ____ No
Radiation therapy	____ Yes ____ No	Chest pain	____ Yes ____ No	Arthritis	____ Yes ____ No
Alcohol/drug dependency	____ Yes ____ No	Blood disorders	____ Yes ____ No	Epilepsy	____ Yes ____ No
Tuberculosis	____ Yes ____ No	Liver disease	____ Yes ____ No	Chemotherapy	____ Yes ____ No
Headaches	____ Yes ____ No	Asthma	____ Yes ____ No	Antidepressants	____ Yes ____ No
Herpes	____ Yes ____ No	Rheumatic Fever	____ Yes ____ No	Stroke	____ Yes ____ No

Others: _____

Do you smoke? ___ Yes ___ No If so how much? _____ Do you take recreational drugs? ___ Yes ___ No
Women: Are you taking Birth Control Pills? ___ Yes ___ No Are you pregnant? ___ Yes ___ No

This is to certify that I, the undersigned, consent to the performing or the procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.

Signed: _____

Account Information

Person financially responsible for the account: _____

Dental History

Are you having any discomfort at this time? If yes please specify: _____
_____
Have you been under the regular care of a dentist?___Yes___No How long since your last dental visit: _____
What was done at that time? _____
Do your gums feel tender or swollen? ___ Yes ___ No
Is there often bleeding when you floss? ___ Yes ___ No
Have you ever been given local anesthetic (freezing)? ___ Yes ___ No
Have you ever had general anesthetic? ___ Yes ___ No
Are you aware of any lump or swelling in your mouth? ___ Yes ___ No
Are you satisfied with the appearance of your teeth? ___ Yes ___ No
Are you anxious to keep your natural teeth? ___ Yes ___ No
Are you tense during your dental visits? ___ Yes ___ No
Are you interested in a method to calm your nerves? ___ Yes ___ No
Describe what you would like done with your teeth: _____
_____

Do you currently experience any of the following?

Loose teeth ____ Yes _____ No	Ear ache ____Yes _____ No	Spaced or crooked teeth ____Yes ____ No
Bad Breath ____ Yes _____ No	Gagging _____Yes _____No	Unexplained nose bleeds ____Yes ____ No
Missing Teeth ____ Yes _____ No	Sore Gums ____Yes ____No	Popping or clicking of the jaw ____Yes ____ No
Bleeding gums ____Yes _____ No	Headache ____Yes ____ No	Unsatisfactory Dentures _____ Yes ____ No

Office Policy

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

I understand that I am ultimately responsible for the total fees associated with the treatment performed.

Date: _____ Patient/ Guardian signature: _____