Name: Mrs. Ms. Mr. _____
Last First Middle Initial Preferred

Gender □F □M Family Status □ Married □ Single □ Child □Other

If child, please list parent's names _____
Mother Father

Home Address _____

_____
City Province Postal Code

Phone: _____
Home Work Cell

Can be best contacted at: (please check) □Home □Work □Cell

Date of Birth _____/_____/_____ Email _____
DD/MM/YYYY permission to e-mail or text yes no

Your Employer _____ Occupation _____

Business Address _____

Your Physician _____ Phone # _____

Previous Dentist _____ Phone # _____

Emergency Contact _____ Phone # _____

How did you hear about our office? _____

Dental Insurance □ Yes □ No

1st Insurance

Company _____

Name of Insured _____

Date of Birth of Insured _____/_____/_____
DD/MM/YYYY

Group / Plan No. _____

Certificate / ID No. _____

2nd Insurance

Company _____

Name of Insured _____

Date of Birth of Insured _____/_____/_____
DD/MM/YYYY

Group / Plan No. _____

Certificate / ID No. _____

Dental History

Do you feel your Dental Health is: Poor Average Excellent

Do you have any dental condition concerns at the present? □ **Yes** □ **No**

If yes, please list _____

When was your last visit to a dentist? _____

When was your last cleaning? _____

Do you have sore, aching or sensitive teeth? □ **Yes** □ **No**

Do your Gums ever Bleed? □ **Yes** □ **No**

Do you have pain or discomfort elsewhere on your face or jaw (TMJ)? □ **Yes** □ **No**

Do you have any loose teeth? □ **Yes** □ **No**

Do you grind or clench your jaw or teeth during the day or night? □ **Yes** □ **No**

Does food catch frequently between any of your teeth? □ **Yes** □ **No**

Have you ever had any complications with local anesthetic (freezing)? □ **Yes** □ **No**

If yes, please explain _____

Have you ever had excessive bleeding during a dental procedure? □ **Yes** □ **No**

Have you ever had complications with nitrous oxide? □ **Yes** □ **No**

Are you Happy with the way your Smile looks? □ **Yes** □ **No**

Would you like Whiter teeth? □ **Yes** □ **No**

Is snoring a problem for you? □ **Yes** □ **No**

Is there anything else about you the Doctor should know about?

If yes, please list _____

Medical History

NAME: _____

Have you had major Surgery? ☐ **Yes** ☐ **No**

If yes, please describe _____

Describe any recent treatment by a physician _____

Are you taking any medications or supplements? ☐ **Yes** ☐ **No**

If yes, please list _____

Do you experience chest pains or shortness of breath? ☐ **Yes** ☐ **No**

Do you now or have you ever had any of the following?

Alcohol/Drug Abuse	☐ **Yes** ☐ **No**	Heart Murmur	☐ **Yes** ☐ **No**
Anemia	☐ **Yes** ☐ **No**	Hemophilia	☐ **Yes** ☐ **No**
Angina	☐ **Yes** ☐ **No**	Hepatitis A B C (circle)	☐ **Yes** ☐ **No**
Anxiety Attacks	☐ **Yes** ☐ **No**	High Blood Pressure	☐ **Yes** ☐ **No**
Arthritis	☐ **Yes** ☐ **No**	HIV/AIDS	☐ **Yes** ☐ **No**
Artificial Heart Valve	☐ **Yes** ☐ **No**	Joint Replacement (hip, knee, e	☐ **Yes** ☐ **No**
Asthma	☐ **Yes** ☐ **No**	Kidney Disease	☐ **Yes** ☐ **No**
Blood Disorder	☐ **Yes** ☐ **No**	Liver Disease	☐ **Yes** ☐ **No**
Cancer	☐ **Yes** ☐ **No**	Low Blood Pressure	☐ **Yes** ☐ **No**
Chemotherapy	☐ **Yes** ☐ **No**	Lung Disease/Tuberculosis	☐ **Yes** ☐ **No**
Congenital Heart Defect	☐ **Yes** ☐ **No**	Psychological Disorder	☐ **Yes** ☐ **No**
Diabetes	☐ **Yes** ☐ **No**	Mitral Valve Prolapse	☐ **Yes** ☐ **No**
Dizziness/Fainting	☐ **Yes** ☐ **No**	Multiple Sclerosis	☐ **Yes** ☐ **No**
Emphysema	☐ **Yes** ☐ **No**	Pacemaker	☐ **Yes** ☐ **No**
Epilepsy/Seizures	☐ **Yes** ☐ **No**	Radiation Therapy	☐ **Yes** ☐ **No**
Frequent Headaches	☐ **Yes** ☐ **No**	Respiratory Problems	☐ **Yes** ☐ **No**
Gag Reflex	☐ **Yes** ☐ **No**	Rheumatic Fever	☐ **Yes** ☐ **No**
Glaucoma	☐ **Yes** ☐ **No**	Sinus Problem	☐ **Yes** ☐ **No**
Hay Fever	☐ **Yes** ☐ **No**	STI	☐ **Yes** ☐ **No**
Head Injuries	☐ **Yes** ☐ **No**	Stomach/Intestinal Problems	☐ **Yes** ☐ **No**
Hearing Disabled	☐ **Yes** ☐ **No**	Stroke	☐ **Yes** ☐ **No**
Heart Attack	☐ **Yes** ☐ **No**	Thyroid Disease	☐ **Yes** ☐ **No**
Heart Disease	☐ **Yes** ☐ **No**	Ulcer	☐ **Yes** ☐ **No**

Please list any other serious medical conditions you have or had in the past:

_____

Do you require pre-medications? ☐ **Yes** ☐ **No**

Do you smoke or chew tobacco? ☐ **Yes** ☐ **No** Vape? ☐ **Yes** ☐ **No** Marijuana? ☐ **Yes** ☐ **No**

Are you Allergic to any of the following?

Aspirin	☐ **Yes** ☐ **No**	Local Anesthetic	☐ **Yes** ☐ **No**
Codeine	☐ **Yes** ☐ **No**	Metals	☐ **Yes** ☐ **No**
Erythrom	☐ **Yes** ☐ **No**	Penicillin	☐ **Yes** ☐ **No**
Iodine	☐ **Yes** ☐ **No**	Sedatives	☐ **Yes** ☐ **No**
Keflex	☐ **Yes** ☐ **No**	Sulfa Drugs	☐ **Yes** ☐ **No**
Latex	☐ **Yes** ☐ **No**	Tetracycline	☐ **Yes** ☐ **No**

Other Allergies _____

For Women:

Are you on Birth Control Pills? ☐ **Yes** ☐ **No**

Are you Pregnant? ☐ **Yes** ☐ **No**

Are you Nursing? ☐ **Yes** ☐ **No**

Signature of patient, parent, or guardian:

Signature: _____ Date: _____