Date: _____

Email Address : _____

Name	Home		Business
Address	Cell		Ext #
City	Prov.		Postal Code
Date of Birth	Age		
How did you hear about us?			
Employer	Occupation		
Physician's Name	City		Phone
Emergency Contact	Phone		Relation to you
Primary Insurance Holder	D.O.B.		Relation to you
Insurance Company Name	Policy #		Cert / I.D. #
Secondary Insurance Holder	D.O.B.		Relation to you
Insurance Company Name	Policy #		Cert / I.D. #

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

1 Do you have or have you ever had a heart condition, heart surgery or heart infection? Yes No

If yes, please provide details: _____

2 Are you currently taking any ASA (aspirin) or blood thinners? Yes No

3 Do you have a LATEX allergy? Yes No

4 Do you now or have you ever had or been exposed to:

H.I.V.		Hepatitis		AIDS	
Diabetes		Asthma		High Blood Pressure	
Anemia		Kidney Disease		Low Blood Pressure	
Rheumatism		Liver Disease		Hyper or Hypo Glycemia	
Epilepsy		Food Allergies		Lung Disease	
Thyroid		Cancer		Repeated Headaches	
Scarlet Fever		Fainting Spells		Tuberculosis	
Stroke		Artificial Joints		Emotional or Nervous Disorders	

Please give details: _____

5 Do you have Osteoporosis? Yes No Do you currently take Fosamax or Actonel? Yes No

6 Any **drug allergies**? _____

7 Please list **all medications** you are taking including herbal ones: _____

8 Have you had an overnight hospital stay in the last 5 years or any major illness? Yes No

Please provide details: _____

9 Are you pregnant? If yes, when are you due? _____ Yes No Not Sure

DENTAL HISTORY

1 Have you ever had local anaesthetic? Yes No

2 Are any of your teeth sensitive to: Heat Cold Sweets

3 Do your gums bleed when: Flossing Brushing

4 Do your gums feel swollen or tender? Yes No

5 Do you catch food between your teeth? Yes No

6 **Do you have any concerns regarding your visit today? If so, please explain:** Yes No

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic when necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services.

Patient (Parent, Guardian) Signature: _____

If parent, guardian, please print name: _____ Date: _____