PERSONAL INFORMATION

NAME ______________________________

ADDRESS ______________________________

CITY __________ PROVINCE __________ POSTAL CODE __________

PHONE RESIDENCE __________ BUSINESS __________ DATE OF BIRTH __________

CELL __________ EMAIL __________

REFERRED BY __________ PHYSICIAN __________

OCCUPATION/EMPLOYER ______________________________

PERSON RESPONSIBLE FOR ACCOUNT ______________________________

INSURANCE CARRIER __________ GROUP NO. __________ S.I.N. __________

MEDICAL HISTORY

	Please check (✓)	YES	NO
1.	Have you ever had a serious illness or are you under the care of a physician now?	☐	☐
2.	Have you had a medical examination in the last year?	☐	☐
3.	Do you use any medicine regularly?	☐	☐
4.	Have you ever had any of the following diseases? (Please Circle) hepatitis, jaundice, diabetes, high blood pressure, tuberculosis, any lung disease, venereal disease, heart attack or heart disease, stroke, epilepsy, cancer, thyroid disease, kidney disease, mental or nervous disease, arthritis or rheumatic fever, stomach problems, allergies, AIDS.	☐	☐
5.	Do you ever have asthma, hay fever, hives or skin rash?	☐	☐
6.	Has any member of your family had diabetes?	☐	☐
7.	Have you ever experienced any unusual reaction to any of the following drugs? (Please Circle) aspirin, penicillin, iodine, sulfonamide (sulfa), barbiturates (sleeping pills), local anaesthesia or other medicine	☐	☐
8.	Do you bruise easily or bleed abnormally?	☐	☐
9.	Do you have any blood disorders such as anaemia (thin blood)?	☐	☐
10.	Have you ever had any injury, surgery or X-ray therapy to your face or jaws?	☐	☐
11.	Do you have a tendency to faint?	☐	☐
12.	Do you have frequent severe headaches?	☐	☐
13.	Do you have a prosthetic implant?	☐	☐
14.	WOMEN ONLY — Are you pregnant? (Which month?__________)	☐	☐
15.	Do you have any disease, condition or problem not listed above that you think the doctor should know about? If yes, please explain __________	☐	☐
16.	Are you HIV positive?	☐	☐

DENTAL HISTORY

		YES	NO
1.	Have you had a regular dental examination (annually) in the past?	☐	☐
2.	Do you have any oral habits such as clenching, grinding your teeth or nail biting?	☐	☐
3.	Have you ever had tooth brushing instruction?	☐	☐
4.	Have you ever had instruction in using dental floss?	☐	☐
5.	What concerns you most about your dental health? __________		
6.	Are you happy with your smile? If not, please explain. __________	☐	☐

Date __________ ______________________________

Patient's Signature

CLINICAL EXAMINATION

EXTRAORAL ______________________________

INTRAORAL SOFT TISSUE ______________________________

PERIODONTIUM/ORAL HYGIENE ______________________________

DENTITION ______________________________

RADIOLOGY ______________________________