Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

		Patient #
Patient Informatio	M (CONFIDENTIAL)	SS#/SIN
Name	(CONFIDENTIAL)	Date
Address	BirthdateCity	Home Phone
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PhysicianOffice Phone
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1. Are you under medical treatment now? 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain 3. Are you taking any medication(s)
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If yes, please explain 3. Are you taking any medication(s)
Sulfa Drugs Barbiturates Sedatives Including non-prescription medicine? If yes, what medication(s) are you taking? Any Metals (e.g. nickel, mercury, etc.) Latex Rubber 5. Have you ever taken Fen-Phen/Reduce? 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? 6. Do you use tobacco? 7. Do you use controlled substances? 8. Do you have or have you had any of the following? Yes No Yes No High Blood Pressure Heart Attack Rheumatic Fever Heart Murmur Swollen Afrikes Hay Fever / Allergies Sulfa Drugs Barbiturates Sedatives Iodine Latex Rubber Other (please list) 11. Do you have a persistent cough or throat dearing not associated with a known illness (lasting more than 3 weeks)? 12. Women Only: a) Are you pregnant or think you may be pregnant? b) Are you nursing? c) Are you taking oral contraceptives? Yes No Yes No Yes No Yes No High Blood Pressure Heart Murmur Hay Fever / Allergies
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? 4. Have you ever taken Fen-Phen/Redux? 5. Have you ever taken Fen-Phen/Redux? 6. Do you use tobacco? 7. Do you use controlled substances? 8. Do you have or have you had any of the following? Yes No Yes No Yes No Yes No High Blood Pressure Heart Attack Rheumatic Fever Heart Murmur Swollen Afikles Angina Hay Fever / Allergies Hay Fever / Allergies Enlight Sedatives Iodine Aspirin. Any Metals (c. g. nickel, mercury. etc.) Latex Rubber. Other (please list) 11. Do you have a persistent cough or throat dearing not associated with a known illness (lasting more than 3 weeks)? 12. Women Only: a) Are you pregnant or think you may be pregnant? b) Are you nursing? c) Are you taking oral contraceptives? Yes No Heart Attack Heart Disease Easily Winded Rheumatic Fever Heart Murmur Swollen Afikles Angina Hay Fever / Allergies
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Any Metals (e.g. nickel, mercury. etc.) Latex Rubber 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? 6. Do you use tobacco? 7. Do you use controlled substances? 8. Do you have or have you had any of the following? Yes No High Blood Pressure Heart Attack Heart Attack Cardiac Pacemaker Rheumatic Ever Swollen Angina Any Metals (e.g. nickel, mercury. etc.) Latex Rubber Other (please list) 11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? 12. Women Only: a) Are you pregnant or think you may be pregnant? b) Are you nursing? c) Are you taking oral contraceptives? Yes No Yes No Yes No Yes No Yes No Yes No Heart Murmur Stroke Stroke Entitling (Sciences)
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8. Do you have or have you had any of the following? Yes No Heart Attack Heart Attack Cardiac Pacemaker Rheumatic Fever Swollen Ankles Angina Hay Fever / Allergies
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Low Blood Pressure Emphysema Radiation Therapy
Epilepsy / Convulsions Cancer Gaucoma
Kidney Disposes Heart Trouble
AIDS or HIV Infection Sexually Transmitted Disease Respiratory Problems
Thyroid Problem Stomach Troubles / Ulcers Mitral Valve Prolapse
Acid Reflix Other
Patient Dental History
Name of Previous Dentist and LocationDate of Last Exam
Yes No Yes No
1. Do your gums bleed while brushing or flossing?
2. Are your teeth sensitive to hot or cold liquids/foods?
3. Are your lean sensitive to sweet or sour liquids/joods/ = 10. Do you bite your lips or cheeks frequently?
7. Do you jeet pain to any of your teeth? = 11. Have you ever had any difficult extractions
3. Do you have any sores or tumps in or near your mouth?
9. Have you mu any nead, need or jaw injuries - 12. Have you ever had any prolonged bleeding
- The state of the
Data (below was at least food)
Difficulty in opening or closing
Difficulty in chewing regarding the care of your teeth and game?
Authorization and Release
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Loughest the above questions have been accurately answered.
diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors
otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. Large to be remarked
I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance henefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services, I agree to be responsible for payment of all services rendered on my behalf or my dependents.
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Doctor's Comments
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