The CONCOURSE DENTAL CENTRE
The art and science of dentistry

PATIENT INFORMATION

Date: _____

Please complete this questionnaire in its entirety as it allows for comprehensive care.
All information is strictly confidential and will remain in this office.

Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐

NAME: _____
Last First Middle

ADDRESS: _____
Street Apt #

_____
City Province Postal Code

HOME PHONE: **BUS PHONE:** **EXT:**

DATE OF BIRTH (D/M/Y): **SEX:** **MARITAL STATUS:**

EMPLOYER: **OCCUPATION:**

EMAIL ADDRESS: **DENTAL INS: YES ☐ NO ☐ COMPANY:**

INS POLICY NO.: **EMPLOYEE NO.:**

SECONDARY INSURANCE: YES ☐ NO ☐

DRIVER'S LICENSE NO.:

FAMILY PHYSICIAN: **PHONE NO.:**

PREVIOUS DENTIST: **LAST VISIT:** **PHONE NO.:**

WHOM MAY WE THANK FOR REFERRING YOU?

IN CASE OF EMERGENCY NOTIFY:

RELATIONSHIP: **PHONE:**

PERSON RESPONSIBLE FOR ACCOUNT (if other than self)

NAME: **PHONE:**

ADDRESS:

OFFICE POLICY

1) PAYMENTS : Payment for service is expected at the end of each visit. Certain circumstances may be given special consideration. Please discuss these with your dentist.

2) APPOINTMENTS: In order to treat you effectively, we will reserve an appointment time solely for you. We require your co-operation in keeping these appointments. If you cannot keep your appointment, we require two business days' notice. Otherwise, a fee will be assessed.

CONFIDENTIAL MEDICAL HISTORY

1. Date of last physical examination:

2. Are you currently under the care of a physician? ..... YES ☐ NO ☐

Please Specify:

3. Are you currently taking any medications, non-prescription drugs or herbal supplements of any kind ..... YES ☐ NO ☐

Please Specify:

4. Have you taken any prolonged medication in the past? (prescription or non-prescription) ... YES ☐ NO ☐

5. Have you had rheumatic fever/heart murmur/mitral valve prolapse? ..... YES ☐ NO ☐

6. Do you have heart disease, an artificial heart valve or pacemaker? ..... YES ☐ NO ☐

Please Specify:

7. Have you had abnormal bleeding? ..... YES ☐ NO ☐

Please Specify:

8. Have you allergies to any drugs or medications? ..... YES ☐ NO ☐

Please Specify:

9. Have you ever been hospitalized and was surgery performed? ..... YES ☐ NO ☐

Please Specify:

10. Do you have or have you had…?

- ☐ Heart Trouble/Attack/Stroke
- ☐ High/Low Blood Pressure
- ☐ Diet Pill Therapy
- ☐ Chest Pain/Angina
- ☐ Blood Disorder
- ☐ Anemia
- ☐ Fainting Spells
- ☐ Surgery
- ☐ Drug/Alcohol Dependency
- ☐ Nervous Disorder
- ☐ Psychiatric Care
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Hepatitis A, B, or C
- ☐ Kidney Disorder
- ☐ Herpes
- ☐ Thyroid Disorder
- ☐ Aids/HIV
- ☐ Cancer
- ☐ Venereal Disease
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Abnormal Weight Change
- ☐ Stroke
- ☐ Epilepsy/Seizures
- ☐ Arthritis
- ☐ Ulcer
- ☐ Swollen Ankles
- ☐ X-ray Therapy
- ☐ Malignant Hyperthermia

11. Are you currently in good health? ..... YES ☐ NO ☐

12. Is there anything else you think you should tell me? ..... YES ☐ NO ☐

13. WOMEN: Are you Pregnant/Breast Feeding? ..... YES ☐ NO ☐

Which Month/Due Date:

14. Do you smoke or chew tobacco products? ..... YES ☐ NO ☐

CONFIDENTIAL DENTAL HISTORY

1. Do you have a specific dental problem at the moment? ..... YES ☐ NO ☐

If yes, explain:

2. Are you satisfied with the appearance of your teeth? ..... YES ☐ NO ☐

3. Describe in your words what we can help you with?

4. Are you tense during dental visits ..... YES ☐ A LITTLE ☐ A LOT ☐ NO ☐

5. Which of the following best describes you?

☐ I am very interested in my oral health ☐ I visit the dentist occasionally

☐ I visit the dentist more or less regularly ☐ I visit the dentist only when I have to

6. Have you been advised to take antibiotics prior to having dental work? ..... YES ☐ NO ☐

7. Do you currently experience...?

☐ Loose/Shifting Teeth	☐ Bleeding Gums	☐ Sore Gums
☐ Sensitive/Hot/Cold Pressure	☐ Bad Breath	☐ Popping or Clicking jaw
☐ Ear Ache	☐ Neck Pain	☐ Headache
☐ Unexpected Nosebleed	☐ Missing Teeth	☐ Spaced or Crooked Teeth
☐ Unsatisfactory Dentures	☐ Gagging	☐ Food Catches
☐ Stained Teeth	☐ Discolored Dark Teeth	

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, have read the foregoing and consent to the performance of the dental procedures agreed to be necessary or advisable. I will assume responsibility for fees associated with those procedures and acknowledge that all payments are due as treatment is rendered, unless otherwise arranged.

Patient's (parent's) Signature: Date:

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