



## 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...?

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

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:

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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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### The Concourse Dental Centre

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TD North Tower, Concourse Level,  
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