White Oaks Mall
Dental Clinic

PATIENT INFORMATION

DATE _____

Dr. ❑
Mr. ❑
Mrs. ❑
Ms. ❑

NAME _____
LAST FIRST MIDDLE

AGE _____ ❑ M ❑ F MARITAL STATUS _____ S.I.N. # _____

ADDRESS _____
No. & STREET CITY PROV/State POSTAL CODE /zip

HOME PHONE _____ DATE OF BIRTH _____
DAY MONTH YEAR

OCCUPATION _____ DRIVER'S LICENCE No. _____

EMPLOYED BY _____ Bus. phone _____

DENTAL INSURANCE ❑ No ❑ Yes - Name of Company _____

SUBSCRIBER NAME _____ Date of Birth _____
DAY MONTH YEAR

SUBSCRIBER'S EMPLOYER _____

Insurance Policy No. _____ I.D. or Certificate No. _____

FAMILY PHYSICIAN _____ PHONE No. _____

PREVIOUS DENTIST _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY NOTIFY: Name _____

Address _____

Relationship _____ Telephone _____

PERSON RESPONSIBLE FOR ACCOUNT (if not the same as above)

Name _____ Phone No. _____

Address _____

CONFIDENTIAL MEDICAL HISTORY

1. Are you presently under the care of a physician?..... ❑ YES ❑ NO
   please specify _____
2. Date of last physical examination _____
3. Are you presently taking any pills, drugs or medication?..... ❑ YES ❑ NO
   please specify _____
   _____
4. Have you taken any prolonged medication in the past? ❑ YES ❑ NO
   Prescription ❑ YES ❑ NO ..... Non-Prescription ❑ YES ❑ NO
   Please specify _____
5. Have you had rheumatic fever? ..... ❑ YES ❑ NO
6. Have you had heart disease or murmur? ..... ❑ YES ❑ NO
7. Do you become breathless easily? ..... ❑ YES ❑ NO
8. Have you had abnormal bleeding? ..... ❑ YES ❑ NO
9. Have you taken steroids (i.e. - cortisone)? ..... ❑ YES ❑ NO
10. Have you had any allergies? ..... ❑ YES ❑ NO
11. Have you allergies to any drugs or medicines? ..... ❑ YES ❑ NO
    Please specify _____
12. Have you been warned against taking any drug or medication? ❑ YES ❑ NO
    Please specify _____
13. Have you ever been hospitalized & was surgery performed? ❑ YES ❑ NO
    Please specify _____
14. Do your ankles become swollen?..... ❑ YES ❑ NO
15. Have you gained or lost excessive weight recently? ..... ❑ YES ❑ NO
16. Have you ever had radiation therapy or chemotherapy? ..... ❑ YES ❑ NO

17. Do you have or have you had? *please check*

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Nervous Problems
- ❑ Thyroid Problems
- ❑ Drug Addiction
- ❑ Heart Trouble
- ❑ Chest Pain
- ❑ Blood Disorders
- ❑ Anemia
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Diabetes
- ❑ Liver Trouble
- ❑ Hepatitis
- ❑ Joint Replacement (i.e. - hip, knee)
- ❑ Herpes
- ❑ Cancer
- ❑ Venereal Disease
- ❑ Tuberculosis
- ❑ Lung Disease (i.e. - Asthma)
- ❑ Stomach / Intestinal Problems (i.e. - Ulcer)
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Psychiatric Care
- ❑ Fainting Spells
- ❑ Kidney Trouble
- ❑ A.I.D.S.
- ❑ Other Health Problems

18. Are you currently in good health? ..... ❑ YES ❑ NO
19. Is there anything else you think you should tell me? ..... ❑ YES ❑ NO
    Please specify _____
20. Are you, or is it possible, that you are pregnant?..... ❑ YES ❑ NO
    If YES, What month?_____

CONFIDENTIAL DENTAL HISTORY

1. Are you having any discomfort at this time? ..... ❑ YES ❑ NO
   please specify_____
2. Have you been under regular care by a dentist? ..... ❑ YES ❑ NO
3. How long since your last dental visit? _____
4. What was done at that time?_____
5. Do you have any dental implants? ..... ❑ YES ❑ NO
6. Do your gums feel tender or swollen? ..... ❑ YES ❑ NO
7. Is your sugar intake: ❑ HIGH ❑ MEDIUM ❑ LOW
8. a) Have you ever been given local anaesthetic (freezing)?.... ❑ YES ❑ NO
   b) Have you ever been given general anaesthetic? ..... ❑ YES ❑ NO
9. Any complications with #8a or #8b? ..... ❑ YES ❑ NO
   Please specify_____
10. Are you aware of any lump or swelling in your mouth? ..... ❑ YES ❑ NO
11. Are you happy with your smile? ..... ❑ YES ❑ NO
12. Are you anxious to keep your natural teeth? ..... ❑ YES ❑ NO
13. Are you tense during dental visits? ..... ❑ YES ❑ NO
14. Are you interested in a method to calm your nerves?..... ❑ YES ❑ NO
15. Describe in your own words what you would like done to your teeth.

_____

_____

16. Do you currently experience? *please check*

- ❑ loose teeth
- ❑ sensitive teeth
- ❑ ear ache
- ❑ headache
- ❑ bleeding gums
- ❑ bad breath
- ❑ popping or clicking in the jaw joints
- ❑ neck pain
- ❑ unexplained nosebleed
- ❑ unsatisfactory dentures
- ❑ spaced or crooked teeth
- ❑ sore gums
- ❑ missing teeth
- ❑ gagging

CONSENT FOR TREATMENT

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any pertinent information. I also consent to my physician or medical specialist being contacted if necessary. I understand that this information is necessary to provide optimum dental care.

DATE _____
month day year

_____ _____
Patient (Parent, Guardian) Signature If parent, guardian, please print:

PATIENT CONSENT: I, the undersigned, consent to the performing of the dental and/or oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic, and/or nitrous gas as indicated, and will assume responsibility for fees associated with procedures.

DATE _____
month day year

_____ _____
Patient (Parent, Guardian) Signature If parent, guardian, please print: