

Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
Preferred Name (nickname): \_\_\_\_\_  
Date of Birth (yyyy-mm-dd): \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Other Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_

Whom may we thank for referring you?  Online Search  Location  Advertising  
 A Friend: Name \_\_\_\_\_  Other: \_\_\_\_\_

Emergency Contact:  
Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Person responsible for payments:  Patient  Other: Name \_\_\_\_\_

## Patient Medical History

Family Physician's Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of last physician exam: (yyyy-mm-dd) \_\_\_\_\_

Do you have or have you had any of the following?

- High Blood Pressure  Heart Murmur  Hepatitis/jaundice  Low Blood Pressure  Thyroid Problem  Sexually transmitted disease  
 Heart Attack  Heart disease  Cancer  Arthritis  Diabetes  Joint Replacement or implant  
 Kidney Disease  Glaucoma  Tuberculosis  Leukemia  Stroke  Epilepsy/Convulsion  
 Rheumatic Fever  Liver Disease  Asthma  Cardiac Pacemaker  Fainting/Seizures  Stomach troubles/ulcer  
 Chest pains/Angina  Emphysema  Radiation therapy  Anemia  Respiratory Problem  Recent weight loss  
 Hay fever/allergies  Others, please specify: \_\_\_\_\_

Are you under medical treatment now?  Yes  No \_\_\_\_\_

Have you ever been hospitalized for any surgical operations or any illness?  Yes  No \_\_\_\_\_

Are you taking any medication (s) including non-prescription medicine?  Yes  No \_\_\_\_\_

Do you smoke or chew tobacco?  Yes  No \_\_\_\_\_

Do you have any allergies to medications / others?  Yes  No \_\_\_\_\_

Please specify allergies: \_\_\_\_\_

Are you taken any birth control medication?  Yes  No Are you pregnant or think you may be pregnant?  Yes  No

### Patient Dental History

I brush my teeth:  More than once a day  Once a day  Once a week  Once a month  Never

I floss my teeth:  More than once a day  Once a day  Once a week  Once a month  Never

Please select what applies to you:

- My gums bleed while brushing or flossing
- I feel pain in one or more of my teeth
- I have had head, neck or jaw injury
- I have had Orthodontic (braces) work done
- My jaw sometimes clicks
- I have jaw pain (jaw joint, ear, or side of the face)
- I clench my teeth
- I have difficulty in opening or closing my mouth
- I experience difficulty in chewing
- I get frequent headaches
- I feel I have bad breath
- I am dissatisfied with the colour of my teeth
- I am unhappy with the appearance of my of my gums
- I have never had professional instructions on the care smile

Do you have any other concerns about your teeth or smile?  Yes, specify: \_\_\_\_\_

No

Previous Dentist Name: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Admin Name

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Admin Name

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Admin Name

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Admin Name