

Medical/Dental History

Patient Name	Medical Alert (for office only)
Preferred Name _____	
Title _____	

Age _____ Birth Date _____ Gender M F Marital Status Married Single Other Child
day / month / year

Occupation _____ Emergency Contact _____ Phone _____

Address _____ City _____ Province _____ Postal Code _____

Phone Home _____ Work _____ Mobile _____ Best time to call _____

Preferred method of contact? Phone SMS Email Email _____

Person responsible for financial matters Self Spouse Parent/Guardian How did you hear about us? _____

Dental Insurance Company Name _____ Policy Holder _____

Policy Number _____ Certificate/Employer ID _____

What is the reason for your visit today?

Prior Dentist's name, address & phone number

When was your last visit to the dentist and what treatments were done?

Did you have x-rays taken?

How often do you have dental visits?

How frequently do you brush your teeth?

3 (+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth?

1 (+) a day 2 - 6 Weekly 1 - 6 Monthly Seldom Never

Do you use sonicare?

Do you use water pick?

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Please check any of the following to indicate Yes in response to the question:

- Are any of your teeth currently causing you pain?
- Do your teeth experience sensitivity to cold or hot temperatures?
- Do your teeth experience any sensitivity to chewing?
- Do you grind your teeth (either consciously or during sleep)?
- Do your gums bleed when you brush or floss?
- Are any of your teeth loose, or are you concerned about any teeth loosening?
- Do you ever experience dry mouth or unpleasant taste in your mouth?
- Have you ever been to a periodontist?
- Have you lost any teeth, if yes why?
- Any complications with extractions?
- Have you ever been to an orthodontist?
- Do you have any retainers?
- Do you currently have any dental implants, dentures, or partials?
- Do you have any veneers, crowns or bridges?
- Did you whiten your teeth?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

Are you currently under the care of a physician due to a specific condition? If yes, please describe

Within the last year, have there been any changes in your general health?

Have you ever been hospitalized due to a surgery or illness? If yes, please describe

What is the date (or approximate date) of your last medical exam?

Are you currently taking any prescription or non-prescription medication? If yes, please list

Your Primary Care Physician's name, address & phone number

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In order of Importance, I generally consider the following benefits (please rank 1 through 7 or 8):

- | | | |
|-------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Comfort | <input type="checkbox"/> Appearance | <input type="checkbox"/> Peace of Mind |
| <input type="checkbox"/> Function | <input type="checkbox"/> Precision | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Durability | <input type="checkbox"/> Health | _____ |

In order of importance, I generally weigh the following costs (please rank 1 through 5 or 6):

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Money | <input type="checkbox"/> Time | <input type="checkbox"/> Personal Effort |
| <input type="checkbox"/> Physical Discomfort | <input type="checkbox"/> Fear/Anxiety | <input type="checkbox"/> Other _____ |

Please check to indicate Yes if you have experienced any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> *Pre-Medication | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> *See Patient Notes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy - *See Notes | <input type="checkbox"/> Dental Phobia | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergy-Aspirin | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Allergy-Codeine | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> HIV+ (AIDS) | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergy-Iodine | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hives | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Allergy-Latex | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Allergy-Penicillin | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> STD |
| <input type="checkbox"/> Allergy-Sulfa | <input type="checkbox"/> Excessive Bruising | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergy-Erythromycin | <input type="checkbox"/> Gastro-Intestinal | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergy-Local Anesth | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hard to Freeze | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hearing Disabled | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Wheelchair |

Do you have any other health issues or allergies?

Have you ever had complications following dental treatment? If Yes, please describe

- To the best of my knowledge, all of the preceding information is true and correct.
 If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

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Please check any of the following to indicate Yes in response to the question:

- Do you use tobacco (smoking or chewing)?
- Do you use recreational drugs?
- Do you consume alcohol?
- Do you require the use of corrective lenses (contacts or glasses)?

WOMEN ONLY:

Are you pregnant? Yes No

If Yes, when is the due date?

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize my dentist to release my information including the diagnosis and records of treatment or examination for myself and dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I understand that I am financially responsible for the outstanding balance for services provided, including those that are not fully covered by insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for by cash, debit, MasterCard, or Visa at the time services are performed.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional service rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature _____ Date _____ Relationship to patient _____

day / month / year