

# Welcome to our office

In order to render the best professional care it is necessary that we become acquainted with the vital information related to each patient. All information is strictly confidential. We appreciate your co-operation in filling out this form carefully and accurately. (PLEASE PRINT, Thank you.)

Patient's Last Name			Mr. Mrs. Dr. Ms.	Given Names		Home Phone	
Apt.	Address			City		Postal Code	
Date of Birth	month	day	year	Preferred Name		Cell Phone	
E-Mail Address			Employer		Business Phone		
In case of emergency, notify				Relationship		Phone	
Name of person responsible for your account				Whom may we thank for referring you?			
<input type="checkbox"/> Self, Other:				Name:			
Do you have Dental Insurance?	Name of Insured Employee			Insurance Company		Employer	
	Group Policy Number			Certificate or I.D. Number			
Policy Holder Date of Birth							
Family Physician		Phone		Previous Dentist		Address or Phone	

## MEDICAL HISTORY

- |   |   |  |
|---|---|--|
|   | Yes   | No   |
| 1. Is your physician currently treating you for any reason?.....  | <input type="checkbox"/>                                | <input type="checkbox"/>                               |
| If yes, explain _____   |   |  |
| 2. Have you ever been hospitalized?.....  | <input type="checkbox"/>                                | <input type="checkbox"/>                               |
| If yes, specify _____   |   |  |
| 3. Do you bruise easily or bleed excessively when cut?.....   | <input type="checkbox"/>                                | <input type="checkbox"/>                               |
| 4. Are you currently taking any pills, drugs or other medicines?.....                                   | <input type="checkbox"/>                                | <input type="checkbox"/>                               |
| If yes, please list   |   |  |
| 1. _____  |   |  |
| 2. _____  |   |  |
| 3. _____  |   |  |
| 4. _____  |   |  |
| 5. Have you ever taken cortisone, steroids, anti-depressants, blood thinners, or thyroid medicine?..... | <input type="checkbox"/>                                | <input type="checkbox"/>                               |
| 7. Do you smoke tobacco products?.....  | <input type="checkbox"/>                                | <input type="checkbox"/>                               |
| 8. Women Only: Are you pregnant? If yes, when do you expect? _____                                      |   |  |
| 9. Do you have any or have you ever had any of the following?   |   |  |
| <input type="checkbox"/> Heart disease or chest pains   | <input type="checkbox"/> Lung or breathing problems     | <input type="checkbox"/> Arthritis                     |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Artificial joint replacements |
| <input type="checkbox"/> Heart murmur   | <input type="checkbox"/> Kidney or liver problems       | <input type="checkbox"/> Epilepsy or seizures          |
| <input type="checkbox"/> Pacemaker or artificial valves   | <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> Syphilis, gonorrhoea, AIDS    |
| <input type="checkbox"/> Rheumatic fever  | <input type="checkbox"/> Thyroid problems               | <input type="checkbox"/> Tumors or cancer              |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Stomach or intestinal problems | <input type="checkbox"/> Radiation therapy             |
| <input type="checkbox"/> Blood disorders or anemia  | <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Shortness of breath           |
| Please specify _____  |   |  |
| _____   |   |  |
| 10. Is there anything else concerning your health that the doctor should know? _____                    | <input type="checkbox"/>                                | <input type="checkbox"/>                               |
| _____   |   |  |
| 11. Are you allergic to any medication or drugs?.....   | <input type="checkbox"/>                                | <input type="checkbox"/>                               |
| If yes, explain _____   |   |  |