CONFIDENTIAL NEW PATIENT FORM

DATE

1. PERSONAL INFORMATION (Please Print)

Name: Mr. ☐ **Mrs.** ☐ **Ms** ☐ **Miss** ☐ _____

Address: _____

(NUMBER) **(STREET)** **(APT)** **(CITY)** **(PROV)** **(POSTAL CODE)**

Date of Birth: _____

Telephone: Home: _____ Work: _____ Cell: _____ E-mail: _____

Occupation: _____ Place of Work: _____ Referred by: _____

Person Responsible for account: Self ☐ Other: _____

Dental Insurance: No If yes, Insurance Name: _____ **Group #:** _____ **Cert #:** _____

In case of emergency please notify: Name _____ Relationship Telephone _____

2. MEDICAL HISTORY

Name of physician: _____ **Telephone:** _____

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

1. **Is your physician treating you now?** No
   If yes, please specify: _____
2. **Do you have any drug allergies?** No
   If yes, please specify: _____
3. **Are you presently taking any medicine or pills?** No
   - **a) Drug** _____ **Reason** _____
   - **b) Drug** _____ **Reason** _____
   - **c) Drug** _____ **Reason** _____
   - **d) Drug** _____ **Reason** _____
   - **e) Drug** _____ **Reason** _____
   - **f) Drug** _____ **Reason** _____
   - **g) Drug** _____ **Reason** _____
   - **h) Drug** _____ **Reason** _____
4. **Do you have a bleeding problem?** No
5. **Are you pregnant (Women)** No
6. **Have you ever had: (check only if yes)**

☐ **Rheumatic fever**	☐ **Hepatitis**	☐ **Heart attack**	☐ **Stomach ulcer**
☐ **Anemia**	☐ **Hayfever**	☐ **Thyroid Problem**	☐ **Mental or nervous disorder**
☐ **Blood disorder**	☐ **Migraine headaches**	☐ **Tuberculosis**	☐ **High blood pressure**
☐ **Cancer**	☐ **Diabetes**	☐ **Epilepsy**	☐ **Asthma**
☐ **HIV**	☐ **Kidney disease**	☐ **Prosthetic joint replacement**	☐ **Latex allergy**
☐ **Heart murmur**			

7. **Is there anything else we should know about your health?** No
   If yes, please specify:

3. DENTAL HISTORY

1. Reason for visit: _____
2. Name of previous dentist _____ Last visit _____
3. Have you ever had complications to local anaesthetic (freezing)? No
4. Do you have bad breath? No
5. Do you or have you ever smoked? No
6. **Do you currently experience: (check only if yes)**

☐ **Loose teeth**	☐ **Sensitive teeth**	☐ **Earache**	☐ **Spaced or crooked teeth**
☐ **Bleeding gums**	☐ **Unexplained nosebleed**	☐ **Unsatisfactory dentures**	☐ **Popping or clicking in jaw**
☐ **Missing teeth**	☐ **Gagging**	☐ **Grinding or clenching teeth**	☐ **Food trap between teeth**
☐ **Unsatisfactory teeth appearance**			

PATIENT CERTIFICATION AND APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Patient Signature _____ Date _____

PATIENT CONSENT

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

Patient Signature _____ Date _____

PAYMENT IN FULL IS DUE AS SERVICES ARE RENDERED UNLESS OTHER FINANCIAL ARRANGEMENTS ARE MADE WITH THE DOCTOR OR PRACTICE MANAGER. THANK YOU.