

**White Oaks Mall
Dental Clinic**

PATIENT INFORMATION

DATE _____

Dr.
Mr.
Mrs.
Ms.

NAME _____

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*

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

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*

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> loose teeth | <input type="checkbox"/> bleeding gums | <input type="checkbox"/> neck pain | <input type="checkbox"/> sore gums |
| <input type="checkbox"/> sensitive teeth | <input type="checkbox"/> bad breath | <input type="checkbox"/> unexplained nosebleed | <input type="checkbox"/> missing teeth |
| <input type="checkbox"/> ear ache | <input type="checkbox"/> popping or clicking in the jaw joints | <input type="checkbox"/> unsatisfactory dentures | <input type="checkbox"/> gagging |
| <input type="checkbox"/> headache | | <input type="checkbox"/> spaced or crooked teeth | |

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: