Patient Information (Confidential)

Date _____

Name_____ Birth date _____ Home Phone_____

Address_____ City _____P Code_____

Email: _____

Check Appropriate Box: □ Single □ Married □ Divorced □ Widowed □ Other Birthplace: _____

Employer_____ Occupation _____Work Phone _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____ Relationship_____

Responsible Party

Name of Person Responsible for this account _____

Relationship _____

Address _____

Home Phone _____ Email: _____

Employer _____ Work Phone _____

Is This Person Currently A Patient in our Office □ Yes □ No

Insurance Information

Name of Insured _____ Birth Date _____

Relationship to patient _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ Province _____P Code _____

Insurance Company _____ Certificate#_____ Group#_____

Do You Have Any Additional Insurance? □ Yes □ No If yes, complete the following:

Name of Insured _____ Birth Date _____

Relationship to patient _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ Province _____ P Code _____

Insurance Company _____ Certificate#_____ Group#_____

MUSEUMDENTAL

Patient Medical History

Physician_____ Phone Number_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	□	□
2. Are you in general good health at this time?	□	□
3. Have you ever been hospitalized for any surgical operations or any illnesses?	□	□
4. Are you taking any medication (s) including non-prescription medicine?	□	□
5. Do you smoke or chew tobacco?	□	□
6. Are you allergic to or have you had any reactions to the following?	□	□
Local Anesthetics (e.g. Novocain)	□	□
Penicillin or other antibiotics	□	□
Sulfa drugs	□	□
Aspirin	□	□
Other	□	□

Women only:

a) Are you pregnant or think you may be pregnant?	□	□
b) Are you taking birth control pills?	□	□

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

	Yes	No		Yes	No		Yes	No
High blood pressure	□	□	Heart murmur	□	□	Hepatitis/jaundice	□	□
Low blood pressure	□	□	Thyroid problem	□	□	Liver disease	□	□
Heart attack	□	□	Heart disease	□	□	Sexually transmitted disease	□	□
Rheumatic fever	□	□	Cardiac pacemaker	□	□	Stomach troubles/ulcer	□	□
Fainting/seizures	□	□	Chest pains/Angina	□	□	Stroke	□	□
Asthma	□	□	Anemia	□	□	Hay fever/allergies	□	□
Epilepsy/convulsion	□	□	Emphysema	□	□	Tuberculosis	□	□
Leukemia	□	□	Respiratory problem	□	□	Radiation therapy	□	□
Diabetes	□	□	Cancer	□	□	Glaucoma	□	□
Kidney disease	□	□	Arthritis	□	□	Recent weight loss	□	□
AIDS or HIV infection	□	□	Joint replacement or implant	□	□	Other_____	□	□

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	□	□	4. Do you clench or grind your teeth?	□	□
2. Do you feel pain in any of your teeth?	□	□	5. Have you had any orthodontic work?	□	□
3. Have you had any head, neck or jaw injuries?	□	□	6. Have you ever had any prolonged bleeding following extractions?	□	□

MUSEUMDENTAL

	Yes	No		Yes	No
7. Have you ever experienced any of the following in your jaw?			9. Have you ever had instruction on the correct method of brushing your teeth?	□	□
a) Clicking	□	□			
b) Pain (joint, ear, side of face)?	□	□	10. Have you ever had instructions on the care of your gums?	□	□
c) Difficulty in opening or closing?	□	□	11. Are you unhappy with the appearance of your smile?	□	□
d) Difficulty in chewing?	□	□	12. Are you satisfied with the colour of your teeth?	□	□
8. Do you have frequent headaches?	□	□	13. Do you feel that you may have bad breath?	□	□

14. Please tell us any concerns you have about your teeth _____

_____

15. Name of Previous Dentist _____ Date of Last Visit _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners which may be submitted electronically. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor

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