

WELCOME TO OUR OFFICE!

For your benefit, please have this form completed and bring it with you to your first visit.

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____

POSTAL CODE: _____ PHONE#: _____ WORK#: _____

Male Female REFERRED BY: _____ DENTIST: _____

INSURANCE: Yes No Dual

* EMAIL ADDRESS: _____

Is any family member a patient at our office? No Yes: _____

Reason for seeking treatment: _____

MEDICAL HISTORY:

Medical Doctor: _____

Please check any of the following conditions which apply to you:

- | | | | |
|---|--------------------------------------|--|--|
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Convulsions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Vision |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Ease of Bruising | <input type="checkbox"/> Sinus Condition |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tooth Ache | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Shortness of Breath |

Please check any of the following illnesses you have ever had:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Angina | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> TB | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Thyroid Problem | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Malignant Hyperthermia | |

Are you suffering from any illness? _____

Please note any previous hospitalizations and surgeries, and the year: _____

List any allergies to medicine or food: _____

List present medication: _____

How would you describe your health? _____

Is there anything in your medical history of which the dentist should be aware? _____

(Women:) Are you pregnant now? _____

DENTAL HISTORY:

1. When was your last dental visit? _____

2. What was done at that visit? _____

3. Have you ever sought orthodontic consultation or had orthodontic treatment previously? _____

4. Do you have difficulty chewing? _____

5. Are you conscious of any pain in your jaw muscle? _____

DATE: _____ SIGNATURE: _____

Thank You!

