



Welcome To Our Dental Office

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency.

PERSONAL INFORMATION

Date: _____ / _____ / _____

Day Month Year

Birthdate

(D/M/YY)

Age

Name Mr/Mrs/Miss/Ms _____

Address _____

Apt# _____

Home Phone _____

City _____

Work Phone _____

Ext _____

Postal Code _____

E-mail _____

Employer _____

Occupation _____

Medical Doctor _____

Phone Number _____

Best Method of Contact? (circle) E-mail _____

Home Phone _____

Work Phone _____

Name of person responsible for this account _____

Do you have dental insurance? _____

Company Name _____

Policy Number _____

I.D.# _____

How did you hear about our office? _____

MEDICAL HISTORY

YES

NO

1. Have you ever had a serious illness, operation, or been hospitalized? YES NO

If yes, explain _____

2. Are you under the care of a physician now? YES NO

If yes, explain _____

3. Have you had a medical examination within the last year? YES NO

If yes, when? _____

4. Are you taking any medication presently? YES NO

If yes, list _____

5. Do you have or have you ever had any of the following? (circle)

Rheumatic Fever

Liver Disease (Jaundice, Hepatitis)

Thyroid Disease

Heart Trouble

Kidney Disease

Lung Disease

High Blood Pressure

Diabetes

Asthma

Heart Murmur

Epilepsy

Blood Disorders

Venereal Disease

Radiation or X-ray Disease

Anemia

Mental or Nervous Disorder

Gastrointestinal Disease

Cancer

Joint Replacement

AIDS / HIV+

Sinusitis

Other _____

6. Do you have any allergies? YES NO

If yes, list _____

7. Are you allergic to any medicines or drugs? YES NO

If yes, list _____

Paramount Dentistry – Stone Church

- | | YES | NO |
|---|--------------------------|--------------------------|
| 8. Have you ever had freezing (local anaesthetic) in your mouth?
If yes, have you had ill effects from it? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you bleed abnormally? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever fainted?
If yes, when? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any chest pains? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do your ankles ever swell? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you gained or lost excessive weight recently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever taken cortisone or steroids? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Is there any history of family disease?
If yes, list conditions: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Is there anything else that the dentist should know regarding your medical history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. To the best of your knowledge, are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you smoke
If yes, how many: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

WOMEN

- | | | |
|---|--------------------------|--------------------------|
| Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, in what stage of pregnancy are you? _____ | | |

DENTAL HISTORY

- | | | |
|--|--------------------------|--------------------------|
| 1. Have you had a complete dental examination with a full series of dental X-rays within the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What was the date of your last dental visit? _____ | | |
| 3. What was done? _____ | | |
| 4. Have you had any extractions?
If yes, did you experience prolonged bleeding after? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had any of the following dental treatments? (circle) | | |
| Root Canal Orthodontics Full or partial dentures | | |
| Periodontal (gums) Crowns or Caps Bridgework | | |
| 6. Are you aware of bad breath or a bad taste in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a bad experience at the dentist? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. What is your present dental problem? _____ | | |

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information. I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures. To change your appointment we require 2 business days' notice or a \$50 charge will apply.

Patient (Parent/Guardian) Signature: _____ Date: _____