

# PATIENT INFORMATION

DATE: \ / \ /

**PATIENT IS AN:** ADULT  CHILD  ADULT UNDER GUARDIANSHIP  NAME OF GUARDIAN: \_\_\_\_\_

Name \_\_\_\_\_ (last) (first) (initial) Nickname \_\_\_\_\_ Mrs.  Ms  Mr.

Home Address \_\_\_\_\_ (street) (city) (prov.) (postal code)

Home Phone ( ) Cellular Phone ( ) Fax # ( )

Date of Birth: \ / \ / Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Driver's License # \_\_\_\_\_ Social Insurance # \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: ( )

Medical Specialist (if presently under care) \_\_\_\_\_ Phone: ( )

**OCCUPATION:** \_\_\_\_\_

Employed By: \_\_\_\_\_ Phone ( ) Ext. \_\_\_\_\_

Spouse Employed By: \_\_\_\_\_ Phone ( ) Ext. \_\_\_\_\_

**DENTAL INSURANCE** Yes  No  Group Policy # \_\_\_\_\_ Certif. # \_\_\_\_\_

Primary Insurance Co. Name: \_\_\_\_\_ Yr. End \_\_\_\_\_

Coverage: Basic % Prosthetics % Crown/Bridge % Ortho % Perio Scaling %

Secondary Ins Co Name \_\_\_\_\_ Group Pol # \_\_\_\_\_ Certif.# \_\_\_\_\_ Yr. End \_\_\_\_\_

Coverage: Basic % Prosthetics % Crown/Bridge % Ortho % Perio Scaling %

**PERSON RESPONSIBLE FOR ACCOUNT** Self  Other  → Name: \_\_\_\_\_

Address \_\_\_\_\_ Drivers License # \_\_\_\_\_

Home Phone ( ) Business Phone ( ) Ext # \_\_\_\_\_ S.I.N: \_\_\_\_\_

**IN CASE OF EMERGENCY** Please Notify \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone: ( ) Business Phone: ( ) Ext. \_\_\_\_\_

Is any other member of your family or relative a patient at our office?

**REASON FOR TODAY'S VISIT** Examination  Emergency  Other  \_\_\_\_\_

Who may we thank for referring you to our office?

MEDICAL HISTORY	PLEASE CHECK YES OR NO. IF NOT SURE, CHECK NS.	NO	NS	YES
Are you presently under Doctor's care? Why?				
Have you been under Doctor's care in the past two years? Why?				
Have you taken any medications, pills or drugs in the past two years?				
Are you presently taking any medications, pills or drugs?				⇒ If YES, list them here:
Are you presently taking any Natural Supplements? e.g., Vitamins or Herbs				⇒
Have you ever had Tonsillitis?				
Have you been hospitalized in the past two years? (If yes, why?)				
Have you had any type of surgery? What & When?				
When was your last complete physical examination?				
When walking, do you ever have to stop because of pain in your chest or shortness of breath?				
Are you on a prescription diet?				
Have you ever been diagnosed as having a tumor or cancer?				
Have you ever taken cortisone/steroid medication?				
Do you experience problems with healing?				
Do you wish to speak privately with the Doctor about any problem?				
Do you smoke? (If yes, how much?)				
Are you currently in good health?				
Do you bruise easily or bleed excessively?				
Have you ever been warned about anaesthetic risks?				