

Patient Name: _____

Chart #: _____

For Office Use Only:

* on blood thinners	yes	no
* Latex allergy	yes	no
* no epinephrine	yes	no
* Pre-meds required	yes	no

New Patient Information- Southside Dental Centre

I. Medical History

Physician's Name: _____ Clinic Name: _____ Phone: _____

1. When was your last medical examination? _____
 2. Are you are taking any medications or drugs at the present time. **Yes No** If yes please list on Medical Update Sheet.
 3. Are you currently taking blood thinners? **Yes No**
 4. Have you had surgery within the past 2 years? If **Yes** please state for what: _____
 5. **Please circle** if you have had treatment for any of the following:
abnormal blood pressure AIDS HIV arthritis blood disorders cancer diabetes epilepsy multiple sclerosis sinusitis
gastrointestinal disease hepatitis A B or C lung disease joint replacement kidney disease mental or nervous disease osteoporosis tuberculosis psychiatric care rheumatic fever thyroid disease venereal disease heart disease
 6. **Please circle** if you have **asthma, hay fever, hives** or **skin rash**.
 7. Have you ever been warned against taking any medication, drug or local anesthetic? **Yes No**
If yes, please state: _____
 8. Are you allergic to latex? **Yes No** Please list any other allergies: _____
 9. Are you prone to fainting? **Yes No** If yes, when was the last time: _____
 10. Do you have shortness of breath? **Yes No** If yes, please explain _____
 11. **Please circle** if have you had **unexplained weight loss**, an **increased thirst** or **frequency in urination**?
 12. **Please circle** if you **bruise easily** or **bleed abnormally**.
- *Women Only:** Are you taking birth control? **Yes No**
Are you pregnant? **Yes No** If yes, in what stage or term of pregnancy? _____

II. Dental History

1. When was your last complete dental examination with a full series of x-rays of your teeth? _____
Dentist's name: _____
2. Please circle if you have had treatment for:
periodontal surgery oral surgery dental implant surgery bite appliance orthodontic treatment
3. Are you interested in a method to calm your nerves? **Yes No**
4. Are you conscious of bad breath or a bad taste in your mouth? **Yes No**
5. Do you favour one side when chewing? **Yes No** If yes please state which side _____
6. Do you use any tobacco products? **Yes No** If yes are you interested in a tobacco cessation program? **Yes No**
7. Do you ever wake up in the morning with a headache or sore facial muscles? **Yes No**
8. Are you involved in any sports activity? **Yes No** If Yes, list sports that you play: _____
9. Are you interested in having whiter teeth? **Yes No**
10. Would you like to straighten your teeth? **Yes No**

Did you know?

We have many cosmetic options to give you the smile of your dreams.

Circle any concerns that you see:

uneven spacing chips crooked teeth staining colour teeth too large teeth too small wear gummy smile

We offer orthodontic services for our adults and children.

We offer two whitening options.

We offer Lumineers to create your custom smile.

For Your Comfort

We have nitrous oxide available to calm you during procedures.

We offer a number of varieties of night guards to suit your needs.

We offer custom made sports mouth guards.

We also offer a number of ways to help you relax during your procedure. From personal CD players, warm blankets, pillows, cool compresses to magazines and televisions in some of our rooms.

Patient Name: _____ Date: _____

Please Sign