

CONFIDENTIAL PATIENT INFORMATION SHEET

PLEASE PRINT

Today's date D ____ M ____ Y ____

Title; _____

Last name; _____

First name; _____

Home address; _____

apt # _____

City; _____

postal code; _____

Phone #; R- (____) _____

B- (____) _____

Occupation; _____

date of birth; D ____ M ____ y ____

Dentist's name; _____

EMAIL _____

Emergency contact; _____

phone; (____) _____

Have you ever had / have any of the following? Please check;

- Broken jaw or teeth
- Braces
- Crowns
- Extraction of wisdom teeth
- Gum treatment
- Root canal treatment
- Denture
- Tooth extraction
- Jaw-joint treatment
- Smoking how many per day? _____

Name of family physician; _____ are you under active care? Yes / No

Phone number; (____) _____

Are you taking any medications? Yes / No If yes, please list; _____

Do you have any allergies ? Yes / No If yes, please list; _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Have you ever had an adverse reaction to any of the following? Please check;

- Aspirin
- Tylenol
- Codeine
- Any other drug

Are you subject to any of the following? Please check;

- Fainting / dizzy spells
- Nervous disorders
- Seizures
- Epilepsy
- Wheezing / asthmatic attacks

Do you have or have you ever had any of the following conditions? Please check;

- Heart problems
- Circulatory problems
- Mitral valve prolapsed
- Rheumatic fever
- Chest pain / angina
- Anemia or blood disorders
- Stomach ulcer
- Hepatitis or jaundice
- Cancer
- Prosthetic joint replacement
- High or low blood pressure
- Diabetes
- Thyroid problem
- HIV infection or AIDS
- Drug or alcohol dependency
- Kidney or bladder problems
- Stroke or heart attack
- Chemotherapy or radiation
- Asthma

=====

Ladies;

Are you pregnant? Yes / No

Are you in menopause? Yes / No

=====

To the best of my knowledge the above information is correct.

Signature of Patient / Guardian; _____