

PATIENT HEALTH RECORD

Patient Information:

Date: _____, 20____

Name: _____

Male Female

Civic Address: _____ Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Patient Phone Numbers:

Home: _____ Work: _____ Cellular: _____

E-Mail Address: _____

Preferred Method of Contact: Home Cellular Work E-Mail Date of Birth: _____ / _____ / _____
(Day) (Month) (Year)

Health Card Number: _____

Occupation: _____ Employer/School: _____

Employer/School Address & Phone Number: _____

Insurance Information:

Insurance Company: _____ Policy Number: _____ ID: _____

Marital Status: Single Married Common-law Divorced Widowed Minor

Spouse's Name: _____ Employer: _____ Work Phone # _____

Emergency Contact: Name: _____ Phone Number: _____

Whom may we thank for referring you? _____

Dental History:

Is there a dental problem you would like treated immediately?: _____

Date of last dental visit: _____ Reason for visit: _____

Name of previous dentist/location: _____

Place a mark on "yes" or "no" to answer each question. If you are unsure of any question, please consult the dentist.Artificial joints (hip, knee) Yes No Fingernail biting Yes No Organ transplant Yes NoBad breath Yes No Food traps between teeth Yes No Orthodontic treatment Yes NoBleeding gums Yes No Grinding teeth Yes No Pain around ear Yes NoBlisters on lips or mouth Yes No Gums swollen or tender Yes No Pain when brushing Yes NoBroken fillings Yes No Implant treatment Yes No Periodontal treatment Yes NoBurning feeling on tongue Yes No Jaw pain or tiredness Yes No Sensitivity to heat / cold Yes NoClenching Yes No Lip or cheek biting Yes No Sensitivity to sweets Yes NoClicking or popping jaw Yes No Loose teeth Yes No Sensitivity when biting Yes NoDry mouth Yes No Mouth breathing Yes No Sores in your mouth Yes NoDo you have any prosthetic tooth replacements? Yes No
(denture / partial / bridge / crown, etc)Are you happy with it? Yes No**Please add anything you feel is important:**

Medical History:

Physician's name: _____ Phone number: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|-----------------------|--|-------------------------|--|----------------------|--|
| AIDS / HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Abnormally | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Women: | |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Birth control pills? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you nursing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Premedication | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reason: | _____ |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Other conditions not mentioned: _____

Please indicate average daily consumption of the following, if applicable:

Alcohol _____	Coffee _____	Recreational drugs _____
Tobacco _____	Tea _____	Type _____
How Long / Since When? _____		

Medications/Allergies (Attach list if necessary)

Medication / dosage	Reason for medication	Medication / dosage	Reason for medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to: Penicillin Aspirin Codeine Latex Other _____

This information is accurate to the best of my knowledge. I authorize the use of this information for treatment consultation with other health care practitioners or for teaching and scientific purposes and I consent to the risks of dental treatment.

Patient signature (or responsible party) _____ Date _____/_____/_____

I hereby authorize release, to my insuring company plans administrator and CDA, information contained in claims submitted electronically and for the communication of information related to the coverage of services described to **SouthWest Dental Surgeons Ltd.** This authorization shall continue in effect until the undersigned revokes the same.

I hereby assign my benefits payable from claims submitted electronically to **SouthWest Dental Surgeons Ltd.** and authorize payment directly to it. This authorization shall continue in effect until the undersigned revokes the same.

Signature of Subscriber

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Date: _____, 20_____.

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