1. PERSONAL INFORMATION (please print)

DATE ____/____/____ (D M Y)

Name: Mr.☐ Mrs.☐ Ms☐ Miss☐ Dr.☐ _____ (GIVEN NAME FAMILY NAME)

Address: _____ (NUMBER STREET APT)

_____ Place of Birth: _____ (CITY PROV POSTAL CODE)

Date of Birth: ____/____/____ (D M Y) Height: _____ Weight: _____

Telephone: Residence _____ Business _____ Ext. _____

Cell _____ Email _____

Occupation: _____ Place of Business : _____

Referred by: _____

Dental Insurance: Yes☐ No☐ If Yes, Insurance Name _____

Cert. or ID # _____ Group (Policy) No. _____

Reason for today's visit: Examination ☐ Emergency ☐ Other _____

Physician's Name: _____ Telephone _____

In case of emergency please notify: Name _____

Relationship _____ Telephone _____

2. MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

1. Are you presently under the care of a physician? _____ Yes☐ No☐
2. Have you ever been hospitalized? _____ Yes☐ No☐
   Specify: _____
3. Has there been any loss of energy, reduction in exercise tolerance, or excessive fatigue to accustomed work? _____ Yes☐ No☐
4. Do you have any allergies? _____ Yes☐ No☐
   Specify: _____
5. Are you presently taking any kind of medication?
   Specify: A) Drug _____ A) Reason _____ Yes☐ No☐
   B) Drug _____ B) Reason _____
   C) Drug _____ C) Reason _____
6. Do you have a bleeding problem? _____ Yes☐ No☐
7. Are you pregnant? _____ Yes☐ No☐
8. Do you presently or have you ever had:

Anaemia ☐	Heart Murmur ☐	Rheumatic fever ☐
Arthritis ☐	Hemorrhage ☐	Rheumatism ☐
Artificial Joints/Hips ☐	High (Low) blood pressure ☐	Scarlet fever ☐
Asthma ☐	Hyper (Hypo) glycemia ☐	Stomach (intestinal) ulcer ☐
Blood Disorder ☐	Kidney disease ☐	Stroke ☐
Cancer ☐	Liver disease (eg Hepatitis) ☐	Thyroid problem ☐
Diabetes ☐	Lung disease ☐	Tuberculosis ☐
Epilepsy ☐	Mental or nervous disorder ☐	Veneral disease ☐
Hay Fever ☐	Migraine headaches ☐	AIDS ☐
Heart disease ☐	Osteoporosis ☐	HIV ☐

9. Have you ever had any illness not included above? _____ Yes☐ No☐
10. Have you ever had a concussion? _____ Yes☐ No☐
11. Have you ever fainted? _____ Yes☐ No☐
12. Any history of familial disease? _____ Yes☐ No☐
13. Has there been any change in appetite? _____ Yes☐ No☐
14. Are you in good health? _____ Yes☐ No☐

Medical Update _____

3. DENTAL HISTORY

1. How frequently do you see your dentist?
   6 months ☐ Yearly ☐ Other _____ Last dental visit _____
2. Have you ever been given oral hygiene instruction in: _____
   Brushing ☐ Flossing ☐ Other _____
3. Have you ever had local anaesthetic? _____ Yes☐ No☐
   Any complications: _____
4. Are any of your teeth sensitive to:
   Cold ☐ Sweets ☐ Heat ☐ Other _____
5. Do your gums bleed when: Brushing ☐ Flossing ☐ Spontaneously ☐
6. Do your gums feel swollen or tender? _____ Yes☐ No☐
7. Do you catch food between your teeth? _____ Yes☐ No☐
8. Are you aware of any loose teeth? _____ Yes☐ No☐
9. Have you ever had a full mouth series of dental x-rays? _____ Yes☐ No☐
10. Does your jaw crack, pop or grate when you open widely? _____ Yes☐ No☐
11. Do you grind or clench your teeth? _____ Yes☐ No☐

Dental update _____

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including taking of x-rays and flouride application as indicated and I will assume responsibility for fees associated with these procedures.

I have been informed of the potential risks of the administration of local anaesthetic such as pain, swelling, trismus, temporary or permanent numbness of the lip, tongue, cheek, teeth, etc., due to nerve damage, etc. I consent to the administration of local anaesthetic and I will assume responsibility for any fees associated.

Patient Consent _____ **Date:** _____

Parent or Guardian Consent for Minors _____ **Date:** _____

PTO

SMILE EVALUATION

Hold a full face mirror 12" - 14" from your face. Smile to show your teeth; take the time to observe your teeth carefully. Then answer the following questions. (It is helpful to have a friend ask you the questions.)

1. Do you like the appearance of your teeth, your smile? ___ Yes ___ No
   If not, explain _____

2. Are your teeth all in alignment (Straight)? ___ Yes ___ No
   If not, explain _____

3. Do you have space that you don't like? ___ Yes ___ No
   If yes, explain _____

4. Do you like the color of your teeth? ___ Yes ___ No
   If not, explain _____

5. Do you like the shape of your teeth? ___ Yes ___ No
   If not, explain _____

6. Are your teeth ...
   chipped ___ protruding ___ hidden ___

7. Do you like the way your teeth close together? ___ Yes ___ No
   If not, explain _____

8. Are there old fillings or dental work that you don't like looking at? ___ Yes ___ No
   If not, explain _____

9. What would you like to change the most in the appearance of your teeth?
   _____

10. How would you like your teeth to look? _____