PATIENT INFORMATION (Please Print)

CHART NO. _____

PATIENT'S NAME ☐ MS. ☐ MR. ☐ MRS. ☐ MISS _____ (LAST / FIRST / MIDDLE)

DATE _____ AGE _____ ☐ M ☐ F

BIRTHDATE _____ (DAY / MO / YR.)

HOME ADDRESS _____ POSTAL CODE

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

OCCUPATION _____ EMPLOYER _____ BUS. PHONE _____

PREVIOUS DENTIST _____ ADDRESS _____ WHEN LAST SEEN _____

PHYSICIAN _____ PHONE _____

SPOUSE INFORMATION

NAME _____ (LAST / FIRST / MIDDLE) BIRTHDATE _____ (DAY / MO / YR.)

EMPLOYER _____ BUS. PHONE _____

IF PATIENT A MINOR

FATHER'S NAME _____ BIRTHDATE _____ (DAY / MO / YR.) BUS. PHONE _____

MOTHER'S NAME _____ BIRTHDATE _____ (DAY / MO / YR.) BUS. PHONE _____

PARENT CONSENT I hereby authorize necessary dental services for: _____

SIGNATURE _____

• Whom may we thank for referring you to our office?

_____

FINANCIAL POLICY

- A service charge of 1.5% per month or 18% per annum ***may*** be applied to accounts with balances over 30 days.
- I acknowledge full responsibility for the payment of all dental services and agree to pay for them in full at the time of service unless other financial arrangements are made in advance.

Signature: _____

Date: _____

OFFICE USE ONLY

MEDICAL HISTORY

	YES	NO
1. Are you under a physician's care at present?	☐	☐
Explain: _____		
2. Do you have any general health problems?	☐	☐
Explain: _____		
3. Major illness in the past?	☐	☐
Explain: _____		
4. Operations (including replacement/artificial joint surgeries)	☐	☐
5. Are you taking any drugs or medications at present? (including over-the-counter meds, vitamins & supplements)	☐	☐
Explain: _____		
6. Have you ever had an allergic reaction to:		
Penicillin	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Local Anesthetics	☐	☐
Other: _____		

	YES	NO
7. Do you bruise or bleed easily?	☐	☐
8. Are you pregnant? (females only)	☐	☐
9. Have you had rheumatic fever?	☐	☐
10. Have you been told you have problems with:		
a) Asthma	☐	☐
b) Blood Pressure	☐	☐
c) Diabetes	☐	☐
d) Hepatitis	☐	☐
e) Arthritis	☐	☐
f) Kidney Disorders	☐	☐
g) Heart Disorders	☐	☐
h) Glaucoma	☐	☐
i) Aids	☐	☐
j) Sexually Transmitted Diseases	☐	☐
11. Do you smoke?	☐	☐

Signature: X _____

Updated _____