WEST HUMBER DENTISTRY
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PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name ______________________ Preferred name ____________ Birth date ____________

If minor, parents names ______________________________________

Home phone ____________ Work phone ____________ E-mail ______________ Best Method of Contact ________

Mailing address ______________________________ City ______________ Postal Code ________

Employer ______________________________ Occupation ______________________________

Emergency Contact Name ______________________ Contact Phone Number ______________________

Medical Doctor Name ______________________ Medical Doctor Phone Number ______________________

How did you hear about our office (i.e. another patient, Internet, advertisement, etc)? ______________________

BILLING, CREDIT, AND INSURANCE INFORMATION:

❑ Not covered by dental insurance

Dental Insurance Company____________ Group/Policy number____________ ID/Social Insurance Number ____________

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company ______________________ Group number ______________

Spouse's birthday ______________ ID/Social Insurance Number ______________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:______________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:______________________
____

Women:

- ❑ May be pregnant
  Expected delivery date: ____________
- ❑ Taking hormones or contraceptives

Do you have any disease, condition, or problem not listed above?______________________

Dental Health History

Have you had a complete dental examination with a full series of dental x-rays within the past 3 years? ❑ yes ❑ no

What was the date of your last dental visit? _______________ What was done? ____

Have you had any extractions? ❑ yes ❑ no If yes, did you experience prolonged bleeding after? ❑ yes ❑ no

Have you ever undergone any of the following dental treatments?

- ❑ Endodontics (Root Canal)
- ❑ Orthodontics (Braces)
- ❑ Fixed Prosthodontics (Crowns/Caps or Bridges)
- ❑ Removable Prosthodontics (Full or Partial Dentures)
- ❑ Periodontics (Gum Surgery)

Are you aware of bad breath or a bad taste in your mouth? ❑ yes ❑ no

Have you ever had a bad experience at the dentist? ❑ yes ❑ no If yes, please explain (optional): _____________________________

What is your present dental concern we may help with? ____

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Patient Certification and Consent

I, ______________________________ (print name), certify that all the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information. I consent to the performing of dental and oral surgery agreed to be necessary or advisable, including the use of local anaesthetic as indicated. I will assume responsibility for fees associated with these procedures.

Patient (Parent/Guardian) Signature____ Date __________________

Thank you for taking time out to complete this form.

Welcome to West Humber Dentistry!