PERSONAL INFORMATION

NAME: _____DATE OF BIRTH D/M/Y: _____
MAILING ADDRESS: _____
HOME PHONE #: _____ WORK: _____ CELL: _____
E-MAIL: _____ HEALTH CARD #: _____
SEX: M __ F __ PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN YOURSELF) _____
NEXT OF KIN: _____ PHONE #: _____
DENTAL INSURANCE: YES ___ NO ____ IF YES, COMPANY: _____
POLICY #: _____ ID #: _____ CARD HOLDER: _____
FAMILY DOCTOR: _____ PHONE #: _____
LAST MEDICAL CHECK-UP: _____ LAST DENTAL CHECK UP: _____
REFERRED BY: _____
ARE YOU A CANADIAN CITZEN: YES _____ NO: _____

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and give the highest possible standard of professional services. All information will be kept strictly confidential.

1. Has there been any change in you health in the past year? YES NO
   If so, what is the condition being treated? _____
2. Have you ever had a serious illness or been hospitalized YES NO
   If so, for what condition? _____
3. Do you have an artificial joint, prosthetic valves, shunts or other implanted devices? YES NO
   If so, for what condition? _____
4. Have you ever had radiation, cobalt or x-ray therapy? YES NO
   If yes, when? _____
5. Women only: Are you pregnant? YES NO
6. Are you taking any medications or drugs at present time? YES NO
   If so, what? _____

7. Have you ever been tested and/or treated for any of the following:

PLEASE CIRCLE

□ Heart Trouble or Disease
□ Rheumatic Fever or Heart Murmur
□ Stroke
□ Thyroid Disease
□ Diabetes
□ Blood Disorders or Anemia
□ Psychological or Psychiatric Disorder
□ Epilepsy
□ Aids/HIV Positive
□ Asthma
□ Arthritis
□ Injury or Surgery to Head or Face
□ Stomach or Intestinal Ulcer
□ Jaundice/Hepatitis/Liver Disease
□ High or Low Blood Pressure
□ Gall Bladder Disease
□ Tuberculosis
□ Lung Disease
□ Kidney Disease
□ Venereal Disease
□ Severe Sore Mouth
□ Hay Fever
□ Prolonged Bleeding
□ Latex Allergy

8. Any other disease or condition not listed above? _____

9. Do you smoke? YES NO
10. Are you allergic to any medication? YES NO
    If yes, to what? _____
11. Do you have allergies? YES NO
    If yes, to what? _____
12. Have you been warned against taking any medications, drug or local anesthetic YES NO
13. **Have you ever had difficulty being frozen? YES NO**
14. Have you ever had difficulty with an extraction? YES NO
15. Have you ever experienced Fainting? YES NO
    Shortness of Breath? YES NO
    Chest pains? YES NO
    Swollen ankles? YES NO
16. Are any of your teeth sensitive to cold, heat, or sweets? YES NO
17. Do your gums bleed during brushing or flossing? YES NO
18. Are you aware of any loose teeth? YES NO
19. Have you ever had root canals? YES NO
    Braces? YES NO
    Gum disease treatment? YES NO
20. Have you ever had a bad dental experience? YES NO

PAYMENT IS DUE IN FULL AT TIME OF SERVICE. IF YOU HAVE DENTAL INSURANCE, WE WILL BE HAPPY TO BILL YOUR INSURANCE COMPANY, ANY PERCENTAGE NOT COVERED IS DUE AT TIME OF SERVICE. FOR YOU CONVIENCE WE ACCEPT INTERAC, VISA, AND MASTERCARD.

PLEASE NOTE: When you make an appointment, we reserve this time for you. As a courtesy to our staff and other patients, please provide at least 24 hours' notice if you need to reschedule your appointment. If you do not provide sufficient notice, THERE IS A $30.00 CHARGE that will be applied. Thank you for your understanding and cooperation. Initial _____

PATIENT (GUARDIAN) CERTIFICATION AND APPROVAL

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.

_____ _____

Patient (Guardian) Signature **Date**

PATIENT (GUARDIAN) CONSENT

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for the fees associated with these procedures.

_____ _____

Patient (Guardian) Signature **Date**

WELCOME TO OUR PRACTICE

ELMSDALE Dental Clinic