PATIENT HISTORY AND INFORMATION

Patient: _____ Date of Birth: ____ / _____ / _____
(Last) (First) (Middle Initial) (Day) (Month) (Year)

Address: _____ City: _____

Postal Code: _____ Tel: (Res.) _____ (Bus.) _____

Cell Phone _____ Email: _____

Family Dentist: _____ Employer: _____

Physician: _____ Physician's Phone#: _____

Referred by (if other than dentist): _____

In case of an emergency, who do we call? _____ Phone # _____

If Patient is a minor, who is legally responsible? _____

INSURANCE INFORMATION

Primary Insurance Dental Insurance Co. _____ Policy or Group # _____ I.D. or Cert. # _____ DEP# _____

Secondary Insurance Dental Insurance Co. _____ Policy or Group # _____ I.D. or Cert. # _____ DEP# _____

Policy Holder's name: _____ Date of Birth: ____ / _____ / _____
(Day) (Month) (Year)

B.C. Care Card # _____

MEDICAL HISTORY

1. Has there been any change in your general health within the past year? ❑ No ❑ Yes
   If yes, please specify _____
2. Are you under the care of a physician for a current problem? ❑ No ❑ Yes
   If yes, describe nature of treatment _____
3. Are you taking any prescription medicines or non-prescription drugs (e.g. aspirin, herbal medications, etc.) of any kind? ❑ No ❑ Yes
   If yes, please specify _____
4. Are you taking bisphosphonates now or have you ever taken them in the past (e.g. Fosamax, Zometa for osteoporosis or bone health)? ❑ No ❑ Yes
   If yes, please specify _____
5. Have you had abnormal bruising or bleeding with previous extractions, surgery, or trauma? ❑ No ❑ Yes
6. Have you had any ALLERGIC or ADVERSE REACTIONS to anesthetics, **latex**, antibiotics, or other medications? ❑ No ❑ Yes
   If yes, please specify _____
7. Do you smoke tobacco? _____ ❑ No ❑ Yes

→

ONLY CHECK IF APPLICABLE

8. Do you have, or have you had, any of the following (if yes, please check):

- ❑ Congenital Heart lesions
- ❑ Heart Murmur or Prolapsed Valve
- ❑ Rheumatic fever or Rheumatic heart disease
- ❑ Prosthetic Heart valve
- ❑ Cardiovascular disease: heart attack, stroke, by-pass
- ❑ Artificial Joints
- ❑ High Blood Pressure
- ❑ Pacemaker
- ❑ Allergies
- ❑ Hepatitis A, B, or C
- ❑ Jaw joint problems
- ❑ Asthma or Hay fever
- ❑ Blood disorders (e.g. anemia)
- ❑ Colitis
- ❑ Diabetes
- ❑ Epilepsy, seizures, fainting
- ❑ Jaundice, Liver disease
- ❑ HIV / AIDS
- ❑ Nervous disorders
- ❑ Kidney problems
- ❑ Radiation treatment
- ❑ Reactions to dental 'freezing'
- ❑ Sinus trouble
- ❑ Surgery
- ❑ Thyroid problems
- ❑ Tumors or Growths
- ❑ Ulcer
- ❑ Respiratory disease

9. Do you have any disease, condition or problem not listed above? ❑ No ❑ Yes

If yes, please specify _____

10. Are you required to take antibiotics prior to dental treatment? (ie joint replacement) ❑ No ❑ Yes

11. Women only: Pregnant? ❑ No ❑ Yes Due Date: _____ Nursing? ❑ No ❑ Yes
Taking birth control pills? ❑ No ❑ Yes If yes, please be advised that **antibiotics may alter the effectiveness of birth control pills**. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

PAIN HISTORY OF YOUR TOOTH OR TEETH

Please answer the following 9 questions:

1. Are you presently having pain? ❑ Yes ❑ No If yes, when did the pain start? _____
2. If no, when did you last have pain and when did it subside? _____
3. Are you taking any medications for your tooth? ❑ No ❑ Yes If yes, please specify _____
   Is it helping? ❑ No ❑ Yes
4. When does it hurt? Circle: cold / heat / chewing / sweet / BY ITSELF / other _____
5. Which of the following would describe your pain? Circle: mild / moderate / severe / sharp shooting / dull throb / continuous / intermittent / other _____
6. If cold hurts your tooth, when the cold is removed, does the pain linger? ❑ Yes: how long? _____ ❑ No
7. On a scale of 1 - 10 (10 being the worst) how would you rate your pain? _____
8. Are you aware of clenching and/or grinding your teeth? ❑ No ❑ Yes
9. Do you wear a night guard? ❑ No ❑ Yes

SIGNATURE _____ DATE _____

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