SL Dental Centre on 4th ST

Patient Information Date: _____

Name: _____ ☐ Married ☐Single ☐ Minor ☐ Male ☐ Female

LAST FIRST M

Address: _____

STREET APT# CITY PROVINCE POSTAL CODE

Birthdate: _____ Telephone: ☐ _____ ☐ _____

MOS. DAY YEAR HOME CELL

Work _____E-Mail: _____

Occupation (or school): _____ Grade: _____

Are there any other family members in our practice? _____

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

Previous Dentist: _____

Person responsible for account:

CHECK ONE:

☐Self ☐ Parents ☐ Spouse ☐ Guardian

Emergency Contact:

Name: _____ Tel. #_____

LAST FIRST

INSURANCE INFORMATION (Plan 1)

Subscriber: _____DOB_____

Employer: _____

Insurance Company: _____

Group / Plan Number: _____

Identification Number: _____

INSURANCE INFORMATION (Plan 2)

Subscriber: _____ DOB_____

Employer: _____

Insurance Company: _____

Group / Plan Number:_____

Identification Number:_____

AUTHORIZATION

The undersigned affirm that the information given in this questionnaire is true and accurate to the best of my/our knowledge. I/We authorize the dental staff to perform such dental services as may be necessary and authorize the release of written records to and referring or treating dentist, physician, medical facility or insurance company for legal documentation.

I/We accept full responsibility for all charges for treatment to the patient regardless of insurance coverage.

_____

Signature(s)

D M Y

__/__/___

Date

☐ Patient ☐Parent ☐ Guardian

☐ Other: _____

Patient Health and Dental History

Name: _____

Date: _____

Allergies on:

Allergy to Latex Allergy to Sulfa Drugs

_____

Allergy to Codeine Allergy to Aspirin

_____

Allergy to Penicillin

Allergy to "Other" _____

List of Medication (s) currently

Please check if you have any OR have had any of the following conditions:

Musculoskeletal

- Arthritis/Gout
- Artificial Joint
- Bruise easily
- Cold sores/Fever Blisters
- Osteoporosis
- Shingles
- Tumors or Growths
- Muscular Dystrophy

Organs

- Asthma
- Liver Disease
- Ulcers
- Hepatitis A B C
- Kidney Problems
- Parathyroid Disease
- Thyroid Disease
- Crohn`s Disease
- Colitis
- IBS

Nervous

- Stroke
- Alzheimer`s Disease
- Epilepsy or Seizures
- Fainting- Dizzy Spells
- Headaches
- Psychiatric Care

Miscellaneous

- Lupus
- Fibromyalgia
- Chronic Fatigue
- Graves Disease
- Lyme Disease
- Sjogren`s Syndrome
- Cancer
- Chemotherapy
- Radiation Therapy
- Other: _____

Depression/Anxiety	Hearing Impairment
Spina Bifida	HPV
Multiple Sclerosis	Herpes Simplex 1 and or 2
Parkinson`s	GORD

Cardiovascular

Anemia	Artificial Heart Valve	Easily winded
Diabetes: Type1 Type2	Atrial Ventricular Fibrillation	Emphysema
High Blood Pressure	Heart Attack/Failure	Frequent Cough
Low Blood Pressure	Irregular Heart Beat	Blood Transfusion
Blood Disease	Heart Pace Maker	Mitral Valve Prolapse
Excessive Bleeding	Chest Pains	Leukemia
Breathing Problems	Congenital Heart Disorder	Sickle Cell
Lung Disease	Hypoglycemia	Hemophilia
Heart Murmur	High Cholesterol	AIDS/HIV

Are you currently under the care of a physician? YES/NO

What is your physicians name?

_____

When was your last medical exam?

_____

Are you on a special diet? YES/ NO

Do you use controlled substances YES/NO

Are you taking oral contraceptives? YES/NO

Do you use tobacco products , if so, how frequently?_____

Have you had any serious neck or head injuries? YES/NO

Have you had major surgery, if so when and what?

_____

Do you have any other health issues or concerns that were not listed?

_____

When was your last dental exam?

_____

Do you experience any pain in your teeth, if so where?

_____

Do you suffer from TMD? YES/NO

Do you grind or clench your teeth, if so, do you wear a Night Guard? YES/NO

Do you snore? YES/NO

Have you had orthodontic treatment (Braces)? YES/NO