◆ ◆ ◆ ◆ COMPLETE FAMILY DENTISTRY ◆ ◆ ◆ ◆

Dr. Robert D. Saunders

ALL INFORMATION IS STRICTLY CONFIDENTIAL & WILL REMAIN WITH THIS OFFICE

DATE: _____

Name: Mr.__ Mrs.__ Ms.__Miss__ Dr.__ _____
Last First Middle

Address: _____
Street Apt. #

_____
City Province Postal Code

Home Phone #: _____ Bus. Phone #:_____ Other # _____

Date of Birth: _____ Marital Status _____
Day / Month / Year

Occupation: _____ Employer: _____

E-Mail: _____

Person Responsible for Account: _____

Dental Insurance: Yes __ No __ Name of Insured or Employee:_____
Insurance Company:_____ Insured's Date of Birth_____
Policy/Plan # _____ Certificate/Subscriber # _____ Employee I.D.#_____

Additional Insurance: Name of Insured or Employee:_____
Insurance Company:_____ Insured's Date of Birth_____
Policy/Plan # _____ Certificate/Subscriber # _____ Employee I.D.#_____

Family Physician Name: _____ Phone #: _____ Last Visit: _____

In Case of Emergency Notify: Name_____ Phone # _____
Relationship: _____

Appointment Office Policy

Payment for services rendered are expected at the end of each dental visit. In order to treat you effectively, we will reserve an appointment time solely for you. We require your co-operation in keeping these appointments. If you cannot keep your appointed time, we require 2 FULL BUSINESS DAYS' NOTICE. Otherwise, a fee will be assessed. _____(initials)

Referral Information

Whom may we thank for referring you to our practice?

__Dental Office __Yellow Pages __Another Patient __Website/Internet Search __Sign

Name of person or Doctor referring you to our practice:_____

CONFIDENTIAL MEDICAL HISTORY

Are you currently taking any pills, drugs or medication? ..... Yes No

Name of Medications and Dosage:

_____

_____

_____

_____

Do you have any **allergies** to any drugs or medicines?..... Yes No
ie, penicillin, Aspirin, etc./please specify _____

Have you ever been hospitalized? Why? _____ Yes No

Do you have a heart murmur or mitral valve prolapse?..... Yes No

Have you ever had rheumatic fever?..... Yes No

Do you have any (replacement)/artificial joints or limbs? ..... Yes No

Do you take **pre-medication** for dental appointments?..... Yes No

Have you ever had abnormal bleeding?..... Yes No

WOMEN: Are you pregnant?..... Yes No

Do you have or have you ever had any of the following? Please check those that apply:

__AIDS
__Allergies
_____
__Anemia
__Arthritis
__Artificial Joints
__Asthma
__Blood Disease
__Cancer
__Diabetes
__Dizziness
__Epilepsy
__Fainting
__Glaucoma
__Growths
__Hay Fever
__Head Injuries
__Hepatitis
__HIV
__High Blood Pressure
__Jaundice
__Kidney Disease
__Liver Disease
__Mental Disorders
__Nervous Disorders
__Pacemaker
__Radiation Treatment
__Respiratory Problems
__Rheumatism
__Sinus Problems
__Stomach Problems
__Stroke
__Swollen Ankles
__Tuberculosis
__Tumors
__Ulcers
__Venereal Disease

Have you ever had any illness not mentioned above?_____

CONFIDENTIAL DENTAL HISTORY

How often do you see a dentist? 6 months ___ Yearly ___ Other _____

How long ago was your last dental visit?_____

Do you have a specific dental problem at the moment?_____

Have you ever had a reaction to dental anaesthetic (freezing)? Yes ____No _____

Are any of your teeth sensitive to Hot ___ Cold ___ Sweets ___ Other _____

Do your gums bleed when brushing ___ flossing _____

Are you aware of any loose teeth?.....Yes ___ No _____

Do you currently experience:

__Ear ache
__Bad breath
__Nosebleeds
__Spaced or crooked teeth
__Discoloured dark teeth
__Headache
__Popping or clicking in the jaw joint
__Unsatisfactory dentures
__Sore gums
__Neck pain
__Gagging
__Stained teeth

On a scale of 1 – 10 (1 being poor, 10 being excellent), how do you rate your smile?

Patient Certification:

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. The practice depends upon reimbursement for services at the time services are rendered. I will assume responsibility for fees associated with these procedures.

Signature (Patient, parent/guardian)_____ Date: _____