Complete Family and Cosmetic Dental Care

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NEW PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________

Address: ______________________________________ City: ___________________

Postal Code: __________________ E-mail Address: ______________________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Emergency Contact: ______________________________ Contact Phone: ______________

MEDICAL / DENTAL HISTORY

Date of last dental visit: ____________________ Date of last X-rays: ____________________

Name of previous Dentist: ____

Have you ever had any reactions to dental freezing? Yes ________ No ________

If yes, please explain: ____

If female, are you pregnant? Yes ________ No ________ Possibly ________

Please check if you have ever been treated for:

____Heart troubles or Stroke
____Tuberculosis or Lung Disease
____ Mental or Nervous Disease
____Stomach or Intestinal Ulcers
____Hepatitis or Liver Disease
____ Rheumatic Fever
____Arthritis or Rheumatism

____Thyroid Disease
____Blood Disorder
____Kidney Disease
____Diabetes
____Injury to Face
____High Blood Pressure
____Growth or Tumor

____Cancer
____Jaundice
____Asthma
____Epilepsy
____A.I.D.S
____Do you grind?
____Do you snore?

Allergies: ____

Prescribed Medication: ____

Is there anything that the Dentist should know regarding your medical status or health that has not been mentioned? ____

Who may we thank for this referral? ____

This is to certify that I, the undersigned, consent to the performing of the dental and / or oral surgery procedures, agreed necessary or advisable, including oral anaesthetic sedation as indicated, and I will assume responsibility for all fees associated with these procedures.

Patient/Parent signature: ______________________________ Date: ____________________

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