Seaside Dental

Name:		**Married Single Child Other**
Address:		**Date of Birth (D/M/Y)**
Postal Code:	**Gender: M F Other**	
Home#: **Work#:**	**Cell#:**	
Employer:	**Email Address:**	
Family members who are patients:		
How did you hear about us?:		
Emergency contact person:		**Phone #**

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Policy Holder	**Policy Holder**
DOB	**DOB**
Insurance Company	**Insurance Company**
Policy #	**Policy #**
ID/Cert#	**ID/Cert#**

Medical/Dental Questions

What are your concerns today with your teeth? _____

_____

When and where was your last dental exam and x-rays? _____

Could we request x-rays be sent to our office? _____

When was your last dental cleaning? _____

Is there anyway we can help improve your smile? _____

Do you clench or grind your teeth? _____

Do you have pain in your teeth, face or jaw? Yes No (please circle)

Do you wear a denture or partial dentures? If yes, date of placement _____

Have you had orthodontic treatment? _____

Have you had treatment from a dental specialist? If yes, what type? _____

_____

List any medications you are currently taking. Please print:

Drug_____ Dosage_____ Reason_____

Drug_____ Dosage_____ Reason_____

Drug_____ Dosage_____ Reason_____

Drug_____ Dosage_____ Reason_____

Drug_____ Dosage_____ Reason_____

Drug_____ Dosage_____ Reason_____

List any vitamins or herbal medication you are currently taking:

List any **allergies** or unfavourable reactions to any medications you have had

When was your last medical exam?
What is the name of your physician?
Are you presently receiving treatment for any illness? Please provide details:

Have you had your blood pressure checked by a health professional in the last year? Y N
Have you ever had any of the following? **Please circle yes or no:**

Diabetes type I II	Yes	No	**High blood pressure**	Yes	No
Bleeding disorder	Yes	No	**Hepatitis A B C**	Yes	No
HIV/Aids	Yes	No	**Tuberculosis**	Yes	No
Tumor/cancer	Yes	No	**Heart Disease/defects**	Yes	No
Radiation/ chemotherapy	Yes	No	**Oral herpes (cold sores)**	Yes	No
Heart Valve replacement	Yes	No	**Osteoporosis/ Arthritis**	Yes	No
Artificial joints	Yes	No	**Asthma**	Yes	No
Latex allergy	Yes	No	**Heart Attack/Stroke**	Yes	No
Physical disability?	Yes	No	**Fainting Dizzy spells**	Yes	No
Mental disability?	Yes	No	**Epilepsy/Seizures**	Yes	No
Lung Disease	Yes	No	**Heartburn/Gastric reflux**	Yes	No
Women: Are you pregnant?	Yes	No	**Do you smoke?**	Yes	No
Due Date:			**Amount/per day**		

Serious operation? Explain:
Serious illness? Explain:

Is there any additional information related to your health that has not been addressed above or your dentist should be aware of?

Patient Statement/Consent and Approval

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted and information.
I authorize the dentist to perform diagnostic procedures and treatment necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary. I understand that my responsibility for payment for all dental services provided for myself or my dependants is mine, and I will assume responsibility for fees associated with these services.

Signature of Patient/Parent or Guardian | Date | Dentist's Signature

Print name of Guardian | Guardian phone #