WELCOME TO OUR DENTAL CLINIC

PERSONAL INFORMATION Date: _____

(Day / Month / Year)

First Name: _____ Last Name: _____
Gender: _____ Health card Number: _____
Date of Birth: D____M____Y_____ Age: _____ Home Phone: _____
Address: _____ Cell: _____
City: _____ Postal Code: _____ Office Home: _____ Ext: _____
Occupation: _____ Title: Mr./Miss/Mrs./Ms. _____
Name of Employer: _____ Medical Doctor: _____
Email: _____
Name of person responsible for this account_____
Do you have dental insurance? _____
Company Name: _____
Policy No.: _____ Emergency Contact: _____
How did you hear about our practice? _____
Do you prefer text or email for appointment confirmation? _____

CONFIDENTIAL MEDICAL/DENTAL HISTORY

1. Date of last physical examination:
2. Are you currently under the care of a physician?
   Yes/No if yes, please specify: _____
3. Are you presently taken any pills, drugs, vitamins, or medications?
   Yes/No if yes, please specify: _____
4. Have you taken any prolonged medication in the past?
   Yes/No if yes, please specify: _____
5. Do you have heart disease/problem, infective endocarditis, hip, knee, or joint replacement?
   Yes/No if yes, please specify: _____
6. Do you become breathless easily? Yes/No
7. Have you had abnormal bleeding? Yes/No
8. Have you taken cortisone or steroid? Yes/No

9. Do you have any allergies to foods, metals, or latex? Yes/No
10. Do you have any allergies to any drugs or medicines? Yes/No
11. Have you ever been hospitalized and/or had surgery performed? Yes/No if yes, please specify: _____
12. Have you gained or lost excessive weight recently? Yes/No
13. Do you have a pacemaker? Yes/No if yes, please specify: _____
14. Are you pregnant? Yes/No N/A
15. Is there anything in your medical or dental history that we have not specifically asked about that we should be aware of? Yes/No If yes, please specify.
16. Have you ever had an organ transplant? Yes/No If yes, please specify.
17. Do you suffer from any of the following? Yes/No If yes, please circle.

Asthma	Stroke	Diabetes	Thyroid Problems
Blood Disorders	High Blood Pressure	Low Blood Pressure	Heart Trouble
Nervous Problems	Kidney Trouble	Anemia	Arthritis
Cancer	Epilepsy/Seizures	Liver Trouble	Chest Pain
Alzheimer's/Dementia	Tuberculosis	Venereal Disease	Scarlett Fever
Sinus Problems	Ulcers	Fainting Spells	Herpes
Hepatitis	COPD (Chronic Obstructive Pulmonary Disease)		HIV Positive/AIDS

CONFIDENTIAL DENTAL HISTORY

1. Are you currently having any discomfort? Yes/No
2. Have you been under the regular care of a dentist? Yes/No
3. When was your last dental visit?
4. What was done at that time?
5. What is your chief complaint?
6. Are you aware of any limps or swelling in your mouth? Yes/No
7. Are you satisfied with the appearance of your teeth? Yes/No
8. Are you anxious to keep your natural teeth? Yes/No
9. Are you tense during dental treatment? Yes/No
10. Have you had serious trouble associated with previous dental treatment? Yes/No if yes, please specify: _____
11. Do you currently experience any of the following: Yes/No. If yes, please circle (please circle)

Loose teeth Sensitive teeth bleeding gums sore gums missing teeth
Bad breath Earache Headache Neck pain unexplained Nosebleeds
Popping jaw joints Clenching/Grinding Spaced or Crooked teeth
Unsatisfactory Dentures

12. Is there anything in your medical or dental history that we have not specially asked about that we should be aware of? Yes/No if yes, please specify:
    _____

OFFICE POLICY

Payments are due when services are rendered. Any alternate arrangements must be clearly discussed with the receptionist before beginning treatment. Please note that your appointment time will be reserved especially for you.

_____ _____

Signature of Patient/Parent/Guardian Date

This is to certify that I, the undersigned, consent to the performing of the dental procedures and medical imaging (including but not limited to x-rays) agreed to be necessary or advisable and that I will assume responsibility of all fees associated with those procedures. I am aware that payment is due as procedures are performed.
I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee.
I have been advised of the office's privacy policy.

I have provided accurate dental and medical history and have not knowingly omitted any information. Should there be any changes in my health status, or any other information provided I will advise this dental office.

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Reviewed by treatment dentist Date

CONSENT FORM FOR DENTAL RADIOGRAPHY (X-RAY)

Dental x rays may be taken as part of the diagnostic process. Intra or extra oral x rays may be taken, to aid in clinical diagnosis and arrive at a suitable treatment plan.

The type of x ray will be decided by the clinician depending on the prevalence of disease, their rate of progression and diagnostic need.

X rays will be taken by a qualified member of staff following the national guidance, practice policy and local rules for radiographs.

RISKS:

● Any radiation the risk associated with dental radiography is primarily that of cell mutation. -However, risks from dental radiography fall into the lowest risk category.

● In case of pregnant women, x rays will be taken only if the benefits outweigh the risks.

● Please inform us if you think you are pregnant.

● For children, doses will be minimized according to protocol.

BENEFITS:

● Extent of bone loss associated with gum disease

● Inter-proximal caries--decay in between the teeth

● Pathology of pulp/nerve/extent of decay

● Integrity of existing fillings

● Verify tooth or root structure

● Impacted teeth /un-erupted teeth

● Pathologic root resorption /other bone pathologies

- I HAVE READ, UNDERSTOOD, AND CONSENT TO HAVING X RAYS TAKEN.

PATIENT OR GUARDIAN SIGNATURE: _____ Date: _____

DENTIST SIGNATURE: _____ Date: _____