PLEASE FILL IN ALL FIELDS

PATIENT INFORMATION A Parent or Guardian will be responsible for decisions relating my treatment YES ☐ NO ☐

Name:_____
First Initial Last

Date of Birth:____/____/____ Email:_____
D M Y

Cell Tel:_____ Home Tel:_____ Work Tel:_____

Address:_____
Street City Postal Code

Preferred method of contact: Home # ☐ Work # ☐ Cell # ☐ Text ☐ Email ☐

☐ I agree to be added to your Facebook page ☐ I agree to subscribe to your newsletter

Preferred time and day for appointment (check all that apply) ☐ Morning ☐ Afternoon ☐ Evening

☐ Monday ☐ Wednesday ☐ Friday ☐ Sunday
☐ Tuesday ☐ Thursday ☐ Saturday

Family Dr:_____ Tel:_____
Emergency Contact:_____ Tel:_____

How did you hear about us?

Referred by (Insert name) ☐ Patient _____ ☐ Family Doctor_____
☐ Bus Shelters ☐ Mobile Sign ☐ Advertising around Shoppers World Mall
☐ Convenient location ☐ Google/Search Engine ☐ Online Review_____
☐ www.tridont.com ☐ Web Marketing ☐ Other (specify)_____

INSURANCE INFORMATION

Do you have extended health or dental insurance? YES ☐ NO ☐
If yes, please provide your card to receptionist, they will make a copy for your file.

DENTAL HISTORY

1. What is the reason for today's visit?_____

2. When was your last dental visit?_____

3. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other_____

4. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never YES NO

5. Do your gums feel swollen or tender?_____ ☐ ☐

6. Do you have bad breath or a bad taste in your mouth?_____ ☐ ☐

7. Do you have food catch between your teeth?_____ ☐ ☐

8. Have you ever had local anaesthetic (freezing)_____ ☐ ☐
If yes, were there any complications? (Please specify) _____ ☐ ☐

9. Have you had any problems with previous dental treatments? Specify_____ ☐ ☐

10. Have you had any of the following: ☐ Bridgework ☐ Crowns or Caps
☐ Full or Partial Denture ☐ Orthodontic (Braces) ☐ Periodontal (Gums) ☐ Root Canal

11. Are you satisfied with your teeth?_____ ☐ ☐

12. Do you have Sleep Apnea?_____ ☐ ☐
If yes, are you using any of the following: ☐ CPAP machine ☐ Oral Appliance

(Continued on reverse side)

MEDICAL HISTORY (this information will remain confidential) YES NO

1. Are you presently under the care of a physician? If so explain_____ ☐ ☐

2. Have you ever had a serious illness or been hospitalized? If so explain_____ ☐ ☐

3. Are you taking any Drugs or medication at this time? ☐ ☐

4. Do you suffer from any allergies (hay fever, latex, etc.)? If so which ones?_____ ☐ ☐

5. Do you bruise easily or have prolonged bleeding? _____ ☐ ☐

6. Have you ever fainted, had shortness of breath or chest pains_____ ☐ ☐

7. Have you ever been warned against using any medication? If so which?_____ ☐ ☐

8. Have you ever taken prolonged medical or non-medical drugs? Specify _____ ☐ ☐

9. Have you ever had an adverse effect to any of the following?

☐ Aspirin ☐ Barbiturates (sleeping pills)
☐ Codeine ☐ Darvon ☐ Local Anaesthetic
☐ Antibiotics: ☐ Penicillin ☐ Sulfonamide

10. Women: YES NO

Are you pregnant?_____ ☐ ☐
Have you reached menopause? _____ ☐ ☐
Are you taking birth control? _____ ☐ ☐

11. Do you or have you ever had any of the following: Please check off appropriate circles

◯ A.I.D.S.	◯ Cancer	◯ Heart disease/attack	◯ Jaundice	◯ Rheumatic/Scarlet fever
◯ Anemia	◯ Circulation Problems	◯ Heart murmur	◯ Kidney disease	◯ Sickle cell disease
◯ Angina pectoris	◯ Congenital heart lesion	◯ Heart Pacemaker/surgery	◯ Liver disease	◯ Sinus Trouble
◯ Anorexia nervosa	◯ Cortisone/steroid	◯ Heart rhythm disorder	◯ Leukemia	◯ Stomach/intestinal prob.
◯ Arthritis/rheumatism	◯ Diabetes	◯ Hepatitis A/B/C	◯ Lung disease	◯ Stroke
◯ Artificial heart valve	◯ Drug/Alcohol dependence	◯ Herpes	◯ Malignant hyperthermia	◯ Thyroid disease
◯ Artificial joints (hip, knee)	◯ Emphysema	◯ High/Low blood pressure	◯ Mental/nervous disorder	◯ Tuberculosis
◯ Asthma	◯ Epilepsy or seizures	◯ H.I.V. positive	◯ Mitral valve prolapsed	◯ Ulcers
◯ Blood Disorders	◯ Glandular disorders	◯ Hodgkins disease	◯ Organ transplant/implant	◯ Venereal disease
◯ Bronchitis	◯ Glaucoma	◯ Hyper (Hypo) Glycemia	◯ Psychiatric treatment	◯ Other_____
◯ Bulimia	◯ Head/neck injuries	◯ Hypertension	◯ Radiation/Chemotherapy	◯ None

12. Children only: Have you recently had any of the following (approximate date)

☐ Chicken Pox ☐ Measles ☐ Mumps
☐ Strep Throat ☐ Tonsillitis

GENERAL RELEASE: I, the undersigned, understand that the information contained in the dental and medical history portion of this chart is important to my treatment. I certify that all the information is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health provider as required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____
Signature ☐ Patient ☐ Parent ☐ Guardian Print Name Date

_____ _____ _____
DDS Signature DDS Print Name Date