PATIENT INFORMATION

STRATHCONA DENTAL WORKS

Date _____
day month year

PERSONAL INFORMATION

Title ○ Mr. ○ Mrs. ○ Ms. ○ Dr. ○ Other _____

Surname _____

First Name _____ Initials _____

Date of Birth _____
day month year

Home Address _____

_____

City _____ Postal Code _____

Telephone H _____

W _____

C _____

Best time to contact _____

At which number: ○ Home ○ Work ○ Cell

E-mail _____

Alberta Health Care # _____

Height _____ Weight _____

Occupation _____

Marital Status _____

Spouse Name _____

Emergency Contact _____

Relationship _____

Phone _____

Personal Physician _____

Phone _____

Date of last dental visit _____
day month year

Regular Dentist _____

Phone _____

○ YES ○ NO May we request previous records?

Who may we thank for referring you?

INSURANCE INFORMATION

○ YES ○ NO Do you have dental insurance?

Carrier 1 _____

Carrier 2 _____

MEDICAL HISTORY

1. ○ YES ○ NO Are you presently receiving medical care? For: _____
2. ○ YES ○ NO Do you have regular physicals? Date of last physical exam: _____
3. ○ YES ○ NO Do you have regular eye exams? Date of last eye exam: _____
4. ○ YES ○ NO Have you had any serious illness or operation or have you ever been hospitalized?
   Illnesses: _____
   Operations: _____
5. ○ YES ○ NO Are you currently taking any drugs or medicine (prescription or non-prescription)?
   List medicines and dosage _____
   _____
6. ○ YES ○ NO Do you take any supplements (vitamins, herbs, homeopathic, etc.). List supplements:
   _____
7. ○ YES ○ NO Do you have any allergies? List allergies: _____
   _____
8. ○ YES ○ NO Are you allergic to or do you have any adverse reactions to any drug or medicine?
   Eg. Local anaesthetic (freezing), general anaesthetic, Penicillin or other antibiotics, barbiturates, sedatives, analgesics (painkillers). _____

PATIENT INFORMATION

STRATHCONA DENTAL WORKS

Date _____ **Patient Name** _____
Day month year

9. Do you have (or have you had) any of the following conditions or problems? Check all that apply.

Now	Past		Now	Past		Now	Past	
O	O	Rheumatic fever	O	O	Asthma/breathing disorder	O	O	Thyroid disease
O	O	Rheumatic heart disease	O	O	Skin rash	O	O	Kidney disease/disorder
O	O	Heart murmur	O	O	Lung disorder	O	O	Alcoholism/substance abuse
O	O	Congenital heart lesions	O	O	Tuberculosis	O	O	Jaundice/liver disease
O	O	Heart trouble	O	O	Fainting spells	O	O	Joint replacement
O	O	Heart attack	O	O	Nervous disorder	O	O	Gastrointestinal disease (eg. Ulcers)
O	O	Heart surgery	O	O	Seizures (eg. Epilespy)	O	O	Bone, muscle or joint disorder
O	O	Arteriosclerosis	O	O	Pregnancy	O	O	Bruising
O	O	Stroke	O	O	Sensitivity to metals	O	O	High blood pressure
O	O	Anemia	O	O	Hay fever	O	O	Bleeding
O	O	Radiation treatment	O	O	Allergy to Latex	O	O	Blood disorder
O	O	Chest pains	O	O	Diabetes	O	O	Delayed healing
O	O	Shortness of breath	O	O	Endocrine disorder	O	O	Chronic disease/ condition

10. O YES O NO Have you gained or lost excessive weight recently? YN. How much?_____

11. O YES O NO To the best of your knowledge, have you come in contact with A.I.D.S. or H.I.V.?

12. O YES O NO Do you have unhealed injuries or inflamed areas, growths, or sort spots in or around your mouth? _____

13. O YES O NO Is there any history of family disease?_____

14. O YES O NO Are you on a special diet?_____

15. O YES O NO Are you currently in good health?_____

16. O YES O NO Do you smoke? How much? _____

17. O YES O NO Do you use smokeless tobacco? How much? _____

18. O YES O NO Do you have any disease or problem not listed that you think we should know about?

_____

_____

SUMMARY

Main reason for today's visit? _____

The above represents a current and accurate history and personal information and I will notify the office of any changes. I hereby consent to examination and only necessary tests / records as determined by the Doctor. I understand and agree that 1.5% per month shall be charged and paid by me on all my accounts or portions thereof unpaid for over 30 days until the account plus interest is fully paid.

Date _____ Signature _____

UPDATES *(not required for new patients)*

Please review the information to ensure it is all current and sign below. Make necessary changes in a different coloured pen.

1. Date_____ Signature _____

2. Date_____ Signature _____

3. Date_____ Signature _____