

Patient Information

Title (Circle one) Mr. Mrs. Ms. Dr. Marital Status _____ Male Female
 Name: First _____ Initial _____ Last _____
 Preferred Name _____ Date of Birth (DD/MM/YYYY) ____/____/____
 Address _____
 City _____ Province _____ Postal Code _____
 Phone H (_____) _____ W (_____) _____ C (_____) _____
 Email _____ How did you hear about our office? _ _____
 Physician Name _____ Telephone Number _____
 Emergency Contact _____ Telephone Number _____

Insurance Information

Primary Insurance Company _____ Secondary Insurance Company _____
 Policy Holder Name _____ Policy Holder Name _____
 Date of Birth (DD/MM/YYYY) ____/____/____ Date of Birth (DD/MM/YYYY) ____/____/____
 Group/Policy/Plan # _____ Group/Policy/Plan # _____
 I.D./Certificate # _____ I.D./Certificate # _____
 Relationship to Patient _____ Relationship to Patient _____

Medical History

1. If you ever had a serious illness or condition requiring hospitalization or extensive medical care, Please specify _____
2. If you are currently under the care of a physician, Please specify reason _____
3. Please specify any prescription or non-prescription drugs taken regularly _____
4. Do you take any **BLOOD THINNERS**? Yes No Please specify _____
5. Have you ever experienced unusual reactions to any of the following?
 Penicillin Local Anesthetic Aspirin Codeine Sulpha Drugs Latex Other
 Please explain _____
6. Do you have AIDS or have you ever tested positive for H.I.V.? _____
7. Have you ever had an injury, surgery, or radiation therapy to your head, face, jaw, or neck? If Yes, Please Specify _____
8. Women only: Are you currently pregnant or suspect you might be? If so, how many weeks? _____
 Are you nursing? YES NO how many weeks have you been nursing? _____
9. Have you had any organ transplants or medical implants? YES NO
10. If you recently had surgery or will be having surgery, do you require premedication for dental treatment? YES NO
 Please specify type of surgery _____

PLEASE COMPLETE REVERSE SIDE

Do you currently experience, or have you ever had any of the following? Please check/circle all that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Hyper/ Hypo Glycemia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stomach Problems/ Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer/ Chemotherapy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease/Emphysema | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mental/Nervous Disorder | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cortisone/Steroid Therapy | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> _____ |

Please elaborate on any of the above:

Previous Dental History

- Former Dentist _____ Last Visit Date _____
- If you have a specific concern you would like addressed, please describe

- How often do you brush your teeth? _____ Floss your teeth? _____
- Are your teeth sensitive to: Hot Cold Sweets Biting and/or chewing
- Do your gums bleed easily? YES NO
- Are you aware of an unpleasant taste in your mouth or bad breath? YES NO
- If you are a smoker, How many years have you smoked? _____ How many per day? _____
- Do you experience any tightness, clicking or pain in the jaw joint? YES NO
- Do you clench or grind your teeth? YES NO
- Do you bite your nails or suck your thumbs or fingers? YES NO
- What cosmetic changes would you make to your teeth?
Straighten Whiten Improve Shape Other _____
- On a scale of 1 to 5 how nervous do you feel coming to the dentist? NOT AT ALL 1 2 3 4 5 VERY

I certify that I have provided an accurate and complete personal and medical/dental history to Jagare Ridge Dental and have not knowingly misled or omitted any information. I have had the opportunity to ask questions and fully understand all of the questions on this form. I authorize the dentist to perform diagnostic procedures and treatment as necessary for proper dental care. I understand that consultation with my medical doctor may be required and I consent to my physician being contacted if necessary. I authorize the free exchange of information between Jagare Ridge Dental and my dental insurance agency including contact information, coverage, treatment planned and completed.

Signature of Patient / Parent / Guardian

Date