Please have this form completed and bring it with you to your first visit. Thank you!

NAME:____ BIRTHDATE: ________________

ADDRESS:____ CITY: ______________________

POSTAL CODE:___________________________ HOME PHONE #:_____________________________

CELL PHONE#:___________________________ WORK#:

EMAIL ADDRESS: ____

- Male ☐ Female INSURANCE: ☐ Yes ☐ No ☐ Dual

REFERRED BY:___________________________ DENTIST: __________________________________

Is any family member a patient at our office? ☐ No ☐ Yes:____

Reason for seeking treatment:____

MEDICAL HISTORY: Medical Doctor:

Please check any of the following conditions which apply to you:

- Severe Headaches ☐ Sore Throat ☐ Bleeding Gums ☐ Joint Pain
- Heart Disease ☐ Convulsions/Epilepsy ☐ High Blood Pressure ☐ Osteoporosis
- Fainting Spells ☐ Chest Pains ☐ Ease of Bruising ☐ Sinus Condition
- Ulcers ☐ Tooth Ache ☐ Dizzy Spells ☐ Shortness of Breath
- Low Blood Pressure

Please check any of the following illnesses you have ever had:

- Rheumatic Fever ☐ Asthma ☐ Angina ☐ Psychiatric Care
- Hepatitis A, B or C ☐ TB ☐ Heart Disease ☐ Autism Spectrum
- Jaundice ☐ Scarlet Fever ☐ Thyroid Problem ☐ Stent
- Diabetes (High or Low) ☐ Mononucleosis ☐ Malignant Hyperthermia ☐ Learning Difficulties
- Anxiety/Depression ☐ HIV/Aids ☐ ADD/ADHD ☐ Herpes Virus (cold sores)
- Joint replacement ☐ Glaucoma/Eye Surgery

Are you suffering from any illness? ____

Please note any previous hospitalizations and surgeries, and the year? ____________________________

____

List any allergies to medicine or food: ____

List present medication: ____

How would you describe your health? ____

(Women:) Are you pregnant now? ____

DENTAL HISTORY:

1. When was your last check up and cleaning? ______________________
2. Is there any outstanding dental work that is still required? ______________________
3. Have you ever sought an orthodontic consultation or had orthodontic treatment previously? ______________________
4. Do you have difficulty chewing? ______________________
5. Are you conscious of any pain in your jaw muscle? ______________________

DATE:______________________ **SIGNATURE**: ______________________