WELCOME TO THE ROY & KALI FAMILY DENTAL CENTER

PATIENT INFORMATION (confidential)

Name: _____ M___F____ Birthdate (d) ___ (m) ____(y) _____ Age____
(Last) (First) (Initial)

Is this patient an: Adult___ Adult with a guardian___ Child ___ Name of parent or guardian _____

Address: _____
(Street) (Apt#) (City) (Province) (Postal code)

Daytime phone: ( ) _____ Work phone ( ) _____ Ext_____ Cell Phone( ) _____

Email:_____
Occupation of Patient, Parent or Guardian_____ Employer: _____ Contact# ( ) _____
May we contact you at work? Yes____ No_____

Marital status _____ Spouse Name: _____ Contact # ( ) _____

Do you have other family members that come here? Yes___ No ___ Who? _____

How did you hear about us? Friend/relative____ Yellow Pages ____ Web Site____ Other (please specify) _____

Dr. may we thank for referring you _____?

Emergency contact: _____ Relationship: _____ Contact# ( ) _____

RESPONSIBLE PARTY (If filling out for a child)

Name of person responsible for this account? _____ Relationship to patient? _____

Address_____ Daytime Phone# ( ) _____
(Street) (Apt#) (City) (Province) (Postal code)

Email: _____ Cell Phone ( ) _____

Is this patient currently a patient in our office? _____ (If not please provide the following information)

Employer_____ _____ Work phone ( ) _____ Birthdate (m) ____ (d) _____(Y) _____

MEDICAL INFORMATION

Family Physician: _____ City: _____ Office phone: ( ) _____
Medical Specialist (if necessary): _____City:_____ Office phone: ( ) _____

DENTAL HISTORY

Are you currently in pain? Yes No

Do you require antibiotic before dental treatment? Yes No

Have you experienced problems associated with any previous dental work? Yes No

Have you now or ever experienced pain in your jaw? Yes No

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles you use? Hard Medium Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? Yes No

If so what? _____

Do your gums bleed or itch? Yes No

Have you ever had periodontal disease? Yes No

Do you have mobility in your teeth? Yes No

Are your teeth sensitive to heat, cold? Yes No

Previous Dentist _____

Last visit date: _____

Why did you leave your previous dentist? _____

What did you like most and least about ANY dentist you have seen? _____

Are you happy with the way your smile looks? Yes No

If not what would you change? _____

Do you regularly consume tobacco____, alcohol___?

Coffee __or tea__?

If so, how much on a daily basis?

MEDICAL HISTORY

Your current dental health is? Good Fair Poor

Date of your last examine? _____

Are you under the care of a physician? _____

If so, what is the condition being treated? _____

Have you had any serious illness, operation?

Or been hospitalized? _____

If so, specify: _____

Are you taking any drugs or medicine: _____?

(Prescription or Non-prescription)

Please specify:

Name of Drug _____ For _____

Name of Drug _____ For _____

Name of Drug _____ For _____

Name of Drug _____ For _____

Name of Drug _____ For _____

Are you allergic or had an adverse reaction to any drug or medicine?

IE: local anaesthetic, penicillin, erythromycin or other

Antibiotics; barbiturates, sedative, analgesics i.e.: codeine or ibuprofen? Yes No

If so, specify: _____

Do you have any allergies? _____

_____

Do you bruise easily or ever had abnormal bleeding? Yes No

Have you ever had radiation treatment? (Cancer) Yes No

Have you ever taken Cortisone or Steroids? Yes No

Is there any history of family disease? Yes No

If so What? _____

WOMEN ONLY

Are you pregnant? _____ or nursing? _____

If pregnant, what month _____

Do presently or have you ever had:

□ Aids	□ Cancer	□ Haemorrhage problems	□ Lung Disease	□ Sinus Trouble
□ Anemia	□ Diabetes	□ High/ Low Blood Pressure	□ Mental/Nervous disorder	□ Stomach (intestinal) Ulcer
□ Arthritis	□ Epilepsy	□ HIV Infection	□ Migraine Headaches	□ Stroke
□ Asthma	□ Hay Fever	□ Hypo/Hyper Glycaemia	□ Rheumatic Fever	□ Thyroid Problem
□ Bladder Disorder	□ Heart Murmur	□ Kidney Disease	□ Rheumatism	□ Tuberculosis
□ Blood Disorder	□ Heart Problems	□ Liver Disease	□ Scarlet Fever	□ Venereal Disease

PATIENT CERTIFICATION AND APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information. I further agree to notify the dentist if my medical status changes or I become aware of any inaccuracy in this information. I do hereby authorize the performance of diagnostic services and performance of dental procedures along with the administration of such anaesthetic and medications deemed necessary.

Patient Signature _____ Date _____

PATIENT (GUARDIAN) CONSENT (FOR MINORS)

I, the undersigned, consent to the performance of diagnostic and dental treatment procedures agreed to be necessary or advised, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures. I further agree to notify the dentist if the medical status of this dependant changes or I become aware of any inaccuracy in this information.

Parent (Guardian) Signature _____ Date _____