NAME ____
(LAST NAME) (GIVEN NAME) (INITIAL)

DATE OF BIRTH ____________ AGE __________ MALE ☐ FEMALE ☐
DAY MO. YR.

HOME ADDRESS ____

CITY ______________________ POSTAL CODE ________________

PHONE NO. - RESIDENCE ________________ BUSINESS ________________

OCCUPATION ______________________ MARITAL STATUS ____________

EMPLOYER ____

PERSONAL PHYSICIAN ____

REFERRED BY ____

ALBERTA HEALTH CARE NUMBER ____

DO YOU HAVE DENTAL INSURANCE? YES ☐ NO ☐

The following information is necessary in order that the dentist may thoroughly diagnose any condition and give you personal attention. Please fill out the form completely. The information is confidential.

MEDICAL / DENTAL HISTORY

YES NO

1. Have you ever had a serious illness or are you under the care of a physician now? ☐ ☐
2. Do you use any medicine regularly or at the present time? ☐ ☐
   If so, for what reason? ______________________________
3. Have you ever had any of the following diseases? *(Please Circle)* Jaundice, diabetes, high blood pressure, tuberculosis, any lung disease, venereal disease, heart attack or heart disease, stroke, epilepsy, cancer, thyroid disease, kidney disease, mental or nervous disease, arthritis or rheumatic fever, stomach problems, hepatitis.
4. To the best of your knowledge have you ever come in contact with the HIV virus? ☐ ☐
5. Do you ever have asthma, hay fever, hives or skin rash? ☐ ☐
6. Do you have any allergies? ☐ ☐
7. Have you ever experienced any unusual reaction to any of the following drugs? *(Please Circle)* aspirin, penicillin, iodine, sulfonamide (sulfa), barbiturates (sleeping pills), local anaesthesia or other medicine.
8. Do you bruise easily or bleed abnormally? ☐ ☐
9. Do you have any blood disorders such as anaemia (thin blood)? ☐ ☐
10. Have you ever had any injury, surgery or x-ray therapy on your face or jaws? ☐ ☐
11. Do you have a tendency to faint? ☐ ☐
12. Do you have frequent severe headaches? ☐ ☐
13. WOMEN ONLY - Are you pregnant? *(Which month ______________)* ☐ ☐
14. When was your last dental check-up? Month __________ Year __________
15. Do you object to dental x-rays? ☐ ☐
16. Do you have any disease, condition or problem not listed above that you think the doctor should know about? ☐ ☐
    ____
    ____
17. Are you happy with the appearance of your teeth? ☐ ☐

TREATMENT / CONSENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

I also consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependants dental care.

Patient's Signature ______________________ Date ______________

Parent's Signature (if patient is under 18) ______________________