ACQUAINTANCE INFORMATION

The data on this confidential form is essential if we are to render the best professional care. We appreciate your co-operation in filling it out carefully so that we will have accurate records. **Please print - Thank you.**

PERSONAL INFORMATION

PATIENT'S LAST NAME	FIRST NAME MIDDLE	HOME PHONE
HOME ADDRESS	CITY/TOWN	POSTAL CODE
DATE OF BIRTH M |D |Y	EMAIL	REFERRED BY	MARITAL STATUS
OCCUPATION	EMPLOYER	BUSINESS PHONE
NAME OF PARTNER	PARTNER'S OCCUPATION	CONTACT NUMBER
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?	IN CASE OF EMERGENCY NOTIFY	PHONE #

PRIMARY INSURANCE INFORMATION/IF YOU HAVE A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING

POLICY HOLDER NAME	DATE OF BIRTH M |D |Y	ADDRESS	
NAME OF INSURANCE COMPANY	GROUP NO.	CERTIFICATE NO.	CONTACT NUMBER

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

POLICY HOLDER NAME	DATE OF BIRTH M |D |Y	ADDRESS	
NAME OF INSURANCE COMPANY	GROUP NO.	CERTIFICATE NO.	CONTACT NUMBER

MEDICAL HISTORY

PHYSICIAN	ADDRESS	PHONE

Are you currently under medical treatment? If so, for what:

Have you had an allergic or unusual reaction to: (Please circle your answer to each question. If yes, please explain)

Aspirin	Yes	No	______	Cosmetics	Yes	No	______
Codeine	Yes	No	______	Metals	Yes	No	______
Dental Anaesthetic	Yes	No	______	Other Medicines	Yes	No	______
Penicillin	Yes	No	______	Are you pregnant?	Yes	No	Due Date ______

Have you ever been treated for:

AIDS/HIV ______	Yes	No	Gastrointestinal Disorders ______	Yes	No	Mitral Valve Prolapse ______	Yes	No
Anemia ______	Yes	No	Glaucoma ______	Yes	No	Pain in the Chest ______	Yes	No
Anorexia or Bulimia ______	Yes	No	Hay Fever ______	Yes	No	Persistent Cough ______	Yes	No
Arthritis ______	Yes	No	Heart Attack ______	Yes	No	Rheumatic Fever ______	Yes	No
Asthma ______	Yes	No	Heart Defects ______	Yes	No	Rheumatoid Arthritis ______	Yes	No
Bleeding Problems ______	Yes	No	Heart Murmurs ______	Yes	No	Shortness of Breath ______	Yes	No
Blood Disorders/Problems ______	Yes	No	Heart Trouble ______	Yes	No	Seizures ______	Yes	No
Bowel Problems ______	Yes	No	Hemophilia ______	Yes	No	Sinus Trouble ______	Yes	No
Cancer ______	Yes	No	Hepatitis A, B or C (Liver Disease) ______	Yes	No	Skin Disorders ______	Yes	No
Coughing up Blood ______	Yes	No	Low/High Blood Pressure ______	Yes	No	Stroke ______	Yes	No
Covid-19 ______	Yes	No	Jaundice ______	Yes	No	Thyroid Problems ______	Yes	No
Diabetes ______	Yes	No	Kidney Problems ______	Yes	No	Tuberculosis ______	Yes	No
Drug or Alcohol Dependency ______	Yes	No	Leukemia ______	Yes	No	Ulcer ______	Yes	No
Emphysema ______	Yes	No	Liver Problems ______	Yes	No	Venereal Disease ______	Yes	No
Epilepsy ______	Yes	No	Lung Disease ______	Yes	No	Other ______		
			Lupus ______	Yes	No	______		

1. Have you ever been hospitalized or had a serious illness or had any surgery?................................ Yes No ______
2. Are you or have you received any psychiatric care and are you receiving medication for this?........... Yes No ______
3. Are you being treated for any condition by a physician?.. Yes No ______
   A. presently? Yes ☐ No☐ ______
   B. in the last 2 years Yes ☐ No☐ ______
4. Have you taken any drugs, pills, medicines or tablets in the last 2 years up to and including the present? Yes No ______
5. Do you ever have asthma, hay fever, hives or skin rash?.. Yes No ______
6. Have you ever had a reaction to any drug including local or general anaesthetic?............................... Yes No ______
7. Are you allergic to latex?... Yes No ______
8. Do you have any other allergies?.. Yes No ______
9. Have you had any unexplained weight loss, increasing thirst/appetite or increase in urination?...... Yes No ______
10. Have you ever taken cortisone?... Yes No ______
11. Do you bleed for a prolonged period of time when cut?.. Yes No ______
12. Do you have any problems with healing when cut or bruised?... Yes No ______

13. Is there any history of disease in your family?.......... Yes No ____________
14. Have you ever fainted?.......... Yes No ____________
15. Is there anything that the dentist should know that has not been mentioned?.......... Yes No ____________
16. Are you pregnant or nursing?.......... Yes No ____________
17. Are you presently taking any drugs or medicines? (please circle).......... Yes No ____________

Antibiotics or sulfa drugs	Drugs for heart trouble	Sedatives or sleeping pills
Anticoagulants (blood thinners)	High blood pressure medicine	Tranquilizers
Antidepressants	Insulin, Diabinese or similar drug	Water pills
Cortisone	Nitroglycerin	Other ____________

18. Have you had any joint replacements?.......... Yes No ____________
19. Have you ever or are you now receiving radiation therapy or chemotherapy?.......... Yes No ____________
20. Do you have any in-dwelling catheters?.......... Yes No ____________
21. Have you ever taken appetite suppressant drugs, for example fenfluramine, phenteremine or de› Yes No ____________
22. Do you smoke? Tobacco Yes ☐ No ☐ Cannabis Yes ☐ No ☐ Vape (e-cigarette) Yes ☐ No ☐ If yes, how much ____________
23. Have we missed anything? ____________

Patient's Signature ____________ Medical history taken by ____________ Date ____________

DENTAL HISTORY

PREVIOUS DENTIST	ADDRESS	DATE OF LAST VISIT	PHONE

1. When was your last dental visit? ____________
2. How often do you have a dental check-up? ____________
3. have you ever had an unfavourable experience at the dentist?.......... Yes No ____________
4. Do you have any discomfort in your teeth due to hot, cold, sweets, biting or chewing pressure?..... Yes No ____________
5. Does food catch between your teeth? __If so, where? ____________
6. Do your gums bleed when brushing or flossing?.......... Yes No ____________
7. Are you conscious of bad breath or a bad taste in your mouth?.......... Yes No ____________
8. Do you favour one side when chewing?.......... Yes No ____________
9. Are you unhappy with the appearance of your teeth, bite or smile?.......... Yes No ____________
10. If you could, would you change anything about your smile?.......... Yes No ____________
11. Do you consider your teeth beyond repair?.......... Yes No ____________
12.Do you ever wake up with a headache or have a tired feeling in your face or jaws?.......... Yes No ____________
13. Do your jaw joints pop, click or grate when opening widely?.......... Yes No ____________
14. Do you clench or grind your teeth?.......... Yes No ____________
15. Have you lost any teeth due to abscess, accident, decay or gum disease? (please circle).......... Yes No ____________
16. Was tooth replacement suggested?.......... Yes No ____________

Please review your medical history on the other side. Indicate whether there is any change in your medical status, or if you are taking any new medications. Please indicate any changes below, with the date and your signature.

1 ____________
DATE SIGNATURE

6 ____________
DATE SIGNATURE

2 ____________
DATE SIGNATURE

7 ____________
DATE SIGNATURE

3 ____________
DATE SIGNATURE

8 ____________
DATE SIGNATURE

4 ____________
DATE SIGNATURE

9 ____________
DATE SIGNATURE

5 ____________
DATE SIGNATURE

10 ____________
DATE SIGNATURE

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE INCLUDING THE USE OF LOCAL ANAESTHETIC AND/OR RELATIVE ANALGESIA AS INDICATED, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

____________ ____________
PATIENT'S (PARENT'S, GUARDIAN'S) SIGNATURE DATE