

PATIENT INFORMATION

STRATHCONA DENTAL WORKS

Date _____
day month year

PERSONAL INFORMATION

Title Mr. Mrs. Ms. Dr. Other _____

Surname _____

First Name _____ Initials _____

Date of Birth _____
day month year

Home Address _____

City _____ Postal Code _____

Telephone H _____

W _____

C _____

Best time to contact _____

At which number: Home Work Cell

E-mail _____

Alberta Health Care # _____

Height _____ Weight _____

Occupation _____

Marital Status _____

Spouse Name _____

Emergency Contact _____

Relationship _____

Phone _____

Personal Physician _____

Phone _____

Date of last dental visit _____
day month year

Regular Dentist _____

Phone _____

YES NO May we request previous records?

Who may we thank for referring you?

INSURANCE INFORMATION

YES NO Do you have dental insurance? Carrier 1 _____

Carrier 2 _____

MEDICAL HISTORY

1. YES NO Are you presently receiving medical care? For: _____

2. YES NO Do you have regular physicals? Date of last physical exam: _____

3. YES NO Do you have regular eye exams? Date of last eye exam: _____

4. YES NO Have you had any serious illness or operation or have you ever been hospitalized?

Illnesses: _____

Operations: _____

5. YES NO Are you currently taking any drugs or medicine (prescription or non-prescription)?

List medicines and dosage _____

6. YES NO Do you take any supplements (vitamins, herbs, homeopathic, etc.). List supplements: _____

7. YES NO Do you have any allergies? List allergies: _____

8. YES NO Are you allergic to or do you have any adverse reactions to any drug or medicine?
Eg. Local anaesthetic (freezing), general anaesthetic, Penicillin or other antibiotics, barbiturates, sedatives, analgesics (painkillers). _____

PATIENT INFORMATION

STRATHCONA DENTAL WORKS

Date _____ Patient Name _____
 Day month year

9. Do you have (or have you had) any of the following conditions or problems? Check all that apply.

Now	Past		Now	Past		Now	Past	
<input type="radio"/>	<input type="radio"/>	Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Asthma/breathing disorder	<input type="radio"/>	<input type="radio"/>	Thyroid disease
<input type="radio"/>	<input type="radio"/>	Rheumatic heart disease	<input type="radio"/>	<input type="radio"/>	Skin rash	<input type="radio"/>	<input type="radio"/>	Kidney disease/disorder
<input type="radio"/>	<input type="radio"/>	Heart murmur	<input type="radio"/>	<input type="radio"/>	Lung disorder	<input type="radio"/>	<input type="radio"/>	Alcoholism/substance abuse
<input type="radio"/>	<input type="radio"/>	Congenital heart lesions	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	Jaundice/liver disease
<input type="radio"/>	<input type="radio"/>	Heart trouble	<input type="radio"/>	<input type="radio"/>	Fainting spells	<input type="radio"/>	<input type="radio"/>	Joint replacement
<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	Nervous disorder	<input type="radio"/>	<input type="radio"/>	Gastrointestinal disease (eg. Ulcers)
<input type="radio"/>	<input type="radio"/>	Heart surgery	<input type="radio"/>	<input type="radio"/>	Seizures (eg. Epilepsy)	<input type="radio"/>	<input type="radio"/>	Bone, muscle or joint disorder
<input type="radio"/>	<input type="radio"/>	Arteriosclerosis	<input type="radio"/>	<input type="radio"/>	Pregnancy	<input type="radio"/>	<input type="radio"/>	Brusling
<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Sensitivity to metals	<input type="radio"/>	<input type="radio"/>	High blood pressure
<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	Hay fever	<input type="radio"/>	<input type="radio"/>	Bleeding
<input type="radio"/>	<input type="radio"/>	Radiation treatment	<input type="radio"/>	<input type="radio"/>	Allergy to Latex	<input type="radio"/>	<input type="radio"/>	Blood disorder
<input type="radio"/>	<input type="radio"/>	Chest pains	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Delayed healing
<input type="radio"/>	<input type="radio"/>	Shortness of breath	<input type="radio"/>	<input type="radio"/>	Endocrine disorder	<input type="radio"/>	<input type="radio"/>	Chronic disease/ condition

10. YES NO Have you gained or lost excessive weight recently? YN. How much? _____
11. YES NO To the best of your knowledge, have you come in contact with A.I.D.S. or H.I.V.? _____
12. YES NO Do you have unhealed injuries or inflamed areas, growths, or sort spots in or around your mouth? _____
13. YES NO Is there any history of family disease? _____
14. YES NO Are you on a special diet? _____
15. YES NO Are you currently in good health? _____
16. YES NO Do you smoke? How much? _____
17. YES NO Do you use smokeless tobacco? How much? _____
18. YES NO Do you have any disease or problem not listed that you think we should know about?

SUMMARY

Main reason for today's visit? _____

The above represents a current and accurate history and personal information and I will notify the office of any changes. I hereby consent to examination and only necessary tests / records as determined by the Doctor. I understand and agree that 1.5% per month shall be charged and paid by me on all my accounts or portions thereof unpaid for over 30 days until the account plus interest is fully paid.

Date _____ Signature _____

UPDATES *(not required for new patients)*

Please review the information to ensure it is all current and sign below. Make necessary changes in a different coloured pen.

1. Date _____ Signature _____
2. Date _____ Signature _____
3. Date _____ Signature _____