DATE: _____ **PATIENT INFORMATION/MEDICAL UPDATES**

Name:_____(Preferred Name): _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (Apt) (City) (Province) (Postal Code)

Date of Birth: _____ Age _____

EMAIL: _____Phone #1: _____Phone #2: _____

Family Doctor: _____ Specialist: _____
Pharmacy Name: _____

EMERGENCY CONTACT: _____ Relationship _____
Contact #_____ Business # _____

Who may we thank for referring you to our office? _____
Is any other member of your family or relative a patient at our office? _____

DENTAL INSURANCE: Yes / No ◯/◯ Insurance Company Name: _____ Policy _____ Certificate_____

PERSON RESPONSIBLE FOR ACCOUNT: Self (☐) Other: _____
(If under the age of 18, please list name and relationship of person responsible for account).

GENERAL CONSENT STATEMENT

I certify that I have read, understand, and accurately completed the personal, medical, and dental histories, to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical/dental histories. As be required, I consent to my physician being contacted regarding any specific medical questions. I authorize the dentist to perform necessary diagnostic procedures and treatment, including anesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

CDA NET AUTHORIZATION

I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically. I understand I am responsible for my account and knowing my insurance policy.

PATIENT AWAREMESS/ACKNOWLEDGEMENT LETTER FOR OFFICE POLICIES

To expedite treatment for everyone, we kindly ask that you respect our appointment policies**. A short notice cancellation fee of $40 will apply if the appointment is cancelled with less than 48 hours' notice. Multiple short notice cancellations or no show appointments will be subject to dismissal from our practice, at our discretion.**

SIGNATURE OF PATIENT: _____ Date: _____

MEDICAL HISTORY/MEDICAL CONDITIONS

Name:_____ **Date:**_____

ALLERGIES

Do you have any allergies? Yes ◯ No ◯. Please check off if you have any of the following allergies:

☐Ibuprofen (Advil)	☐ Naproxen	☐Penicillin	☐Sulpha Drugs	☐Local Anesthetic or Epinephrine
☐Aspirin	☐ Toradol	☐Erythromycin	☐Tetracycline	☐Topical Anesthetic/Benzocaine
☐Tylenol 2,3,4	☐ Demerol	☐Clindamycin	☐Metal	☐Nitrous Oxide
☐Codeine	☐ Valium	☐Zithromycin	☐Latex	
☐Oxycodone	☐ Percocet	☐Cefalexin		

Please list any other allergies including medications and foods:

_____

Are you presently under a Doctor's Care? Why?_____

Have you been hospitalized in the past two years? Please specify: _____

Have you had any type of surgery? What & When ? _____

When was your last medical exam?_____

Please list your medications below:

Are you on a prescription diet?	**YES** ◯	**NO** ◯
Do you experience problems with healing?	**YES** ◯	**NO** ◯
Do you bruise/ bleed easily?	**YES** ◯	**NO** ◯
Do you smoke, vape, cannabis?	**YES** ◯	**NO** ◯
Do you drink alcohol?	**YES** ◯	**NO** ◯
Are you currently in good health?	**YES** ◯	**NO** ◯

_____
_____
_____
_____
_____
_____

Please INDICATE yes or no beside each of the following if you currently have or have had previously.

	Yes	No		Yes	No		Yes	No
Malignant Hypothermia	◯	◯	Asthma	◯	◯	Diabetes or Hypoglycemia	◯	◯
Stomach/Intestinal Issues	◯	◯	Sinus Trouble	◯	◯	Artificial joints/Hips	◯	◯
High Blood Pressure	◯	◯	Emphysema	◯	◯	Arthritis/Rheumatism	◯	◯
Low Blood Pressure	◯	◯	Frequent Cough	◯	◯	Pain in Jaw Joints	◯	◯
Heart Attack/ Cardiac Arrest	◯	◯	Lung Disease	◯	◯	Head/Neck Injuries	◯	◯
Artificial Heart Valve	◯	◯	Sleep Apnea	◯	◯	Osteoporosis	◯	◯
Pacemaker/Defibrillator	◯	◯	Tuberculosis	◯	◯	Epilepsy or Seizures	◯	◯
Mitral Valve Prolapse	◯	◯	Kidney Disease	◯	◯	Ulcers/ Acid Reflux	◯	◯
Heart Murmur	◯	◯	Glandular Disorder	◯	◯	Mental Nervous Disorder	◯	◯
Rheumatic Fever	◯	◯	Thyroid Disease	◯	◯	Depression/ Anxiety	◯	◯
Stroke	◯	◯	Liver Disease	◯	◯	Herpes/ Cold Sores	◯	◯
Stents	◯	◯	Blood Disorders	◯	◯	AIDS (HIV Positive)	◯	◯
Cancer/Tumor	◯	◯	Anemia	◯	◯	Hepatitis A/ B/ C	◯	◯
Chemotherapy	◯	◯	Circulation Problems	◯	◯	Drug/Alcohol Addiction	◯	◯
Radiation/Cobalt Treatment	◯	◯	Hemophilia	◯	◯	Transdermal Nicotine Patches	◯	◯

Please inform us of any other medical conditions not mentioned above and/or any special considerations including cognitive, sensory, or physical so we can make your visit more comfortable:

_____

_____

SIGNATURE OF Patient: _____