PATIENT INFORMATION

Patient Name _____ Date _____
First Last

Adult ❑ Child ❑ Male ❑ Female ❑ Date of Birth Month / Day / Year

Address _____ City _____ Postal Code _____

Contact information

Home ( ) _____ Cell ( ) _____ Work ( ) _____

Email _____

Occupation _____ Employer _____

Please indicate what time of the day is best to contact you:
Any time ❑ Days only ❑ Evenings ❑ Weekends ❑

How did you hear about our office?
_____

Do you have any family members at the practice?
Yes ❑ No ❑

In case of emergency contact:
Name _____ Tele ( ) _____

Person Responsible For Financial Matters

Self ❑ Spouse ❑ Parent/Guardian ❑ Other ❑ If different from above: please specify

Name _____
First Last

Address _____ City _____ Postal Code _____

Date of Birth Month / Day / Year Home ( ) _____

Dental Insurance Information

Primary

Name of insured _____
Date of Birth Month / Day / Year
Employer _____
Insurance Company _____
Group or Policy No. _____
Certificate of ID No. _____

Secondary

Name of insured _____
Date of Birth Month / Day / Year
Employer _____
Insurance Company _____
Group or Policy No. _____
Certificate of ID No. _____

I understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and I have not knowingly omitted information. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I assume all responsibility for all fees associated with my own or my dependants dental work,

Patients / Guardian signature: _____ Date: _____

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email info@oakwooddental.ca
website www.oakwooddental.ca

MEDICAL HISTORY

Are you presently under the care of a physician? ❑ Yes ❑ No please explain _____

Have you ever been hospitalized? ❑ Yes ❑ No please explain _____

Are you taking any medications at this time? ❑ Yes ❑ No please explain _____

Have you had any adverse side effects to any of the following medications?
Antibiotics ❑ Aspirin ❑ Codeine ❑ Local Anesthetic ❑

Have you ever been warned against taking any other medication? ❑ Yes ❑ No

please explain _____

Do you have any allergies? Please check the following that apply:
Hayfever ❑ Latex ❑ Antibiotics ❑ Other ❑ please explain _____

Women only - Are you currently Pregnant ❑ Nursing ❑ Menopause ❑ Taking birth control ❑

Have you been treated for / or currently receiving treatment for any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	AIDS / HIV	❑	❑	Cortisonel Steroid	❑	❑	Jaundice
❑	❑	Anemia	❑	❑	Diabetes	❑	❑	Kidney disease
❑	❑	Artificial heart valve	❑	❑	Epilepsy	❑	❑	leukemia
❑	❑	Arthritis / Rheumatism	❑	❑	Heart diseasel attack	❑	❑	lung disease
❑	❑	Artificial joints	❑	❑	Heart murmur	❑	❑	Sickle cell disease
❑	❑	Asthma	❑	❑	Mentall nervous disorde	❑	❑	Sinus trouble
❑	❑	Blood disorders	❑	❑	Heart surgery	❑	❑	Stroke
❑	❑	Blood pressure high/low	❑	❑	Heart rhythm	❑	❑	Tuberculosis
❑	❑	Bronchitis	❑	❑	Hepatitis AlBIC	❑	❑	Ulcers
❑	❑	Cancer	❑	❑	Herpes	❑	❑	Venereal disease
❑	❑	Congenital heart lesions	❑	❑	Hypertension	❑	❑	Thyroid problems

Dental History

Reason for today's visit? Emergency ❑ Exam ❑ other ❑ please explain _____

How often do you see a dentist? 3 - 6 months ❑ 6 - 12 months ❑ When needed ❑

When was the last time you went to dentist? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Gums bleed when brushing	❑	❑	Do you have bad breath	❑	❑	Dentures
❑	❑	Gums bleed when flossing	❑	❑	Does food get -caught	❑	❑	Root canal
❑	❑	Does your jaw pop or crack	❑	❑	Bridge	❑	❑	Braces
❑	❑	Do you grind you teeth	❑	❑	Crowns or caps	❑	❑	Surgical extraction

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