CONFIDENTIAL PATIENT RECORD

Patient Name: First_____Last_____

Date of Birth: Day:____ Mo:_____ Yr:_____ Gender (circle): Female/Male Medical Alert:_____

Address: _____Postal Code:_____

Phone:
(H)_____(W)_____(C)_____

Email Address:
_____

Family Doctor: _____Phone Number:_____

Whom may we thank you for referring you?_____

MEDICAL HISTORY

1. Are you in good health now? Yes ____ No____ If No, please explain_____
2. Are you presently under the care of a physician? Yes ____ No____ If No, please explain_____
3. Are you currently taking any medications? Yes___No_____Please List:_____
4. Are you allergic to or ever had a reaction to any of the following: (Please circle all that apply)
   Penicillin Sulpha Drugs Local Anaesthetic(Freezing)
   Latex Codeine Aspirin(ASA) other_____
5. Do you have any other allergies? Yes_____No_____
6. Have you ever taken cortisone or steroid medication? E.g. Prednisone Yes_____No_____
7. Have you ever had chemotherapy or radiation therapy? Yes_____No_____
8. **Do you smoke or chew tobacco? Yes_____No_____**
9. Do you bleed more/longer than normal after a cut/bruise/surgery/previous tooth removal? Yes_____No_____
10. Have you been a patient in the hospital in the last 2 years? Yes_____No_____
    If yes, please explain: _____
11. Have you ever had a serious illness or operation? Yes_____No_____
12. Do you know or have you ever had any of the following conditions? (Please circle all that apply)

Heart Trouble	Joint Surgery	Thyroid Disorder
Breathing Problems	Stroke	HIV Positive
Asthma	Sexually Transmitted Infections	Kidney Positive
Rheumatic Fever	Heart Defect	High or Low Blood Pressure
Arthritis	Mental Illness	Epilepsy or Seizure
Diabetes	Tumours or Cancer	Liver Disease
Blood Disorders	Hepatitis	Tuberculosis (TB)
Hormonal Disorder	Immune Deficiency	Multiple Sclerosis (MS)

Other_____

13. **Women**: Are you pregnant? Yes_____No_____If yes, which trimester?_____
14. Is there anything else we should know about your health?_____
    _____

DENTAL HISTORY

1. What dental condition(s) concern you at present?_____
2. When was your last dental exam & hygiene appt?_____
3. Previous dentist or clinic name:_____
4. Have you had any complications or difficulty with previous dental treatment? Yes_____No_____
5. Are your teeth sensitive to: Hot_____Cold_____Sweet_____Other_____
6. Do your gums bleed when: Floss_____Brushing_____Never_____
7. Do your gums feel swollen or tender? Yes_____No_____
8. Do you have bad breath or a bad taste in your mouth? Yes_____No_____
9. Are you interested in having teeth whitening? Yes_____No_____
10. Do you grind your teeth and have TMJ problems? Yes_____No_____
11. How do you rate yourself as a dental patient? Calm_____Slightly Nervous_____Apprehensive_____

CONSENT FOR TREATMENT

I hereby certify that the Medical and Dental histories are accurate and complete to the best of my knowledge. I consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anaesthetic or any drugs as indicated:

(Children- under 16 years of age must have parent or guardian signature)

Date: _____ Signature:_____

DENTAL FEE

I understand that the fees for my dental treatment may not be recovered by/or may exceed my plan benefits. I understand that I am financially responsible to my dentist for what is not covered by my dental insurance.

Date: _____ Signature:_____

ELECTRONIC SUBMISSIONS

I hereby assign my benefits payable from claims submitted electronically to Skyview Ranch Dental Clinic and authorize payment directly to the dental office. I authorize release to my insuring company plan administrator, the information contained in claims submitted electronically.

Date: _____ Signature:_____