

Last Name: First Name (legal): Preferred name:

Address: City: Province: Postal Code:

Home Ph: Mobile: Work:

Date of Birth: Day: Month: Year: Email Address:

Married Single Divorced Widowed Minor Other Gender: Male Female

Financially responsible for this account? Self Guardian Other:

How did you hear about our office?:

Reason for today's visit:

Emergency Contact Name: Relation: Phone No.:

DENTAL INSURANCE**Primary Coverage**

Member's Name:

Member's DOB:

Insurance Co:

Group No:

ID No:

Employer/School:

Relation:

Primary Coverage

Member's Name:

Member's DOB:

Insurance Co:

Group No:

ID No:

Employer/School:

Relation:

Physician's Name: Physician's City:

Approximate date of last physical examination/visit to a MD:

Have you been hospitalized in the past 3 years? Y N

Have you ever had a major operation? Y N If yes, what kind/when?:

Please list any medications you are currently taking:

Please list any additional medications taken in the past 3 years:

Do you have any allergies? (Ex. Penicillin, Ibuprofen, Codeine, Aspirin, Latex). If yes, please specify:

Do you have any sensitivity/reactions towards any medications?

Please turn over and complete the other side.

The following information is vital in case of an emergency situation (and for emergency prevention). This information is strictly confidential. Please check "Yes" or "No" to the following conditions or treatments which you **have had** or currently **have**:

Alzheimer's Disease	Y	N	Emphysema	Y	N	Liver Disease	Y	N
Allergy/Anaphylaxis	Y	N	Endocrine Disease	Y	N	Lung Disease	Y	N
Anemia	Y	N	Epilepsy/Seizures	Y	N	Muscle Damage/Trauma	Y	N
Arthritis/Joint Pain	Y	N	Fainting/Dizziness	Y	N	Organ/Medical Transplant	Y	N
Artificial Heart Valve	Y	N	Gastrointestinal	Y	N	Osteoporosis	Y	N
Artificial Joints	Y	N	Glaucoma	Y	N	Psychiatric Treatment	Y	N
Asthma	Y	N	Hay Fever	Y	N	Radiation Therapy	Y	N
Autoimmune Disease	Y	N	Head/Neck Injury	Y	N	Respiratory	Y	N
Blood Disease	Y	N	Heart Attack/Failure	Y	N	Rheumatic Fever	Y	N
Blood Transfusion	Y	N	Heart Murmur	Y	N	Scarlet Fever	Y	N
Bruise Easily	Y	N	Heart Pacemaker	Y	N	Seizures	Y	N
Cancer/Tumor	Y	N	Heart Surgery	Y	N	Sickle Cell Disease	Y	N
Chemotherapy	Y	N	Hemophilia	Y	N	Sinus Trouble	Y	N
Chest Pain/Discomfort	Y	N	Hepatitis A, B, C	Y	N	Sleep Apnea	Y	N
Circulation Problems	Y	N	High/Low Blood Pressure	Y	N	Stroke	Y	N
Diabetes	Y	N	HIV/AIDS	Y	N	Thyroid Disease	Y	N
Drug/Alcohol Addiction	Y	N	Kidney Disease	Y	N	Tuberculosis	Y	N

Other conditions not listed above/more details for conditions listed:

Do your gums bleed when you brush/floss?	Y	N	Are you pregnant?	Y	N
Do you experience clicking or pain in your jaws?	Y	N	Do you feel dizzy when reclined?	Y	N
Any previous difficulty with freezing?	Y	N	Do injuries or cuts take a long time to heal?	Y	N
Are you aware of any clenching/grinding habits?	Y	N	Do you bruise easily or bleed a lot when injured?	Y	N
Do you wear a nightguard appliance?	Y	N	Are you interested in sedation?	Y	N
Are your teeth sensitive to hot, cold, or sweet?	Y	N	Are you a smoker?	Y	N

When was your last dental examination by a dentist?

When was the last time that you had dental x-rays taken?

When was your last dental cleaning by a dental hygienist?

What causes you anxiety at the dental office?

Do you have any concerns regarding the appearance or functioning of your teeth?

I understand that photographs and "selfies" are not permitted in the dental operatory.

By signing this form, I state that all the above information provided is true and complete to the best of my knowledge, and I am giving my consent for the Doctors and staff of Dedicated Dental Care to complete examinations and treatment on myself (or my dependent, as indicated) that is discussed and agreed upon by myself (the undersigned) and Doctors Kanda/Nicholls. I understand that all account balances are due upon day of service and that Dedicated Dental Care does not maintain an assigned benefits relationship with any insurance companies. All fees are between myself (the patient) and Dedicated Dental Care directly.

Patient/Guardian Signature: Date:

Dedicated Dental Care Staff: Date: