

WELCOME TO OUR OFFICE – SUNSHINE DENTAL CENTRE

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All answers will be considered confidential. Thank you.

ABOUT YOU

Name :	Preferred Name :	
Address :		
City :	Province :	Postal Code :
Home Phone :	Business Phone :	Cell Phone :
Birthdate : M/D/Y	Male/Female :	Occupation :
E-Mail :		
Emergency Contact : Name/Phone # :		
Would you prefer (please circle):	Appointment Confirmations via:	Text / Email / Phone
	Emailed Statements:	yes / no

FINANCIAL INFORMATION

PRIMARY INSURANCE

Policy Holder :	Relationship to Holder :
Insurance Company :	Group/Policy # :
Policy Holder Birthdate :	Policy ID/Certificate #:
Employer :	

SECONDARY INSURANCE

Policy Holder :	Relationship to Holder :
Insurance Company :	Group/Policy # :
Policy Holder Birthdate:	Policy ID/Certificate #:
Employer :	

This is to certify that all of the information that I, the undersigned, have provided is complete and accurate.

SIGNATURE :

DATE:

MEDICAL HISTORY

Present Physician :

Phone # :

Last Visit :

Reason for visit? :

Current Medications : *(Please specify if none)*

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Please List Any Allergies : Medications:

(Please specify if none)

Other:

Do you have any history of asthma, hay fever or skin rashes?

Yes / No

Have you ever had a reaction to a drug, medication or other?

Yes / No

Codeine, aspirin, antibiotics, latex, dental anaesthetic(freezing), other :

Please list :

Have you ever had heart problems?

Yes / No

Murmur, prosthetic cardiac valve, previous endocarditis,

congenital heart disease, cardiac transplantation, angina, stroke, other :

Please list :

Do you smoke ? Packs/day

Yes / No

Do you consume marijuana? Daily/weekly?

Yes / No

Do you have any blood disorders, or problems with bleeding?

Yes / No

Please CIRCLE if you have any of the following :

Epilepsy	Lung disease/COPD	Angina	Venereal Disease
Nervous Disorder	Tuberculosis (TB)	HIV	Creutzfeldt-Jakob Disease
Headaches/Migraines	Anemia	Heart Surgery	Blood Transfusion
Fainting/Dizziness	Kidney Problems	Hepatitis A/B/C	Sleep Apnea
Thyroid Disease	Jaundice	High/Low Blood Pressure	Drug Addiction
Sinus Problems	Ulcers	Chemotherapy	Rheumatic Fever
Glaucoma	Arthritis	Steroids	Diabetes
Prosthetic implants	Joint replacements	Radiation Therapy	Clostridium Difficile
Autism	ADHD	Prolonged Cough	Frequent Diarrhea/Crohns
VRE / MRSA	Alzheimers/Dementia	Auto-Immune Disorder :	

Do you have any conditions not listed :

For Women Only : Are you pregnant? Due Date:

UPDATES : *For office use*

1. Date:

2. Date:

3. Date:

DENTAL HISTORY

Patient Name :

Last Dentist :

Phone # :

Reason for last visit :

Last X-Rays :

Dental concerns at this time:

What have your previous dental experiences been like?

What is your goal for future dental treatments? Are you satisfied with the appearance of your teeth?

Have you ever noticed any signs of periodontal disease?

Yes / No

(Bleeding gums, recession, loose teeth or moving teeth)

Do you have sensitive teeth?

Yes / No

Please CIRCLE if you have any of the following :

Clenching/Grinding

Tension/Migraine headaches

Clicking/Popping/Grinding in Joint

Pain on Yawning/Chewing

Sore Teeth/Jaw Upon Waking

Sore Teeth when Biting

Difficulty Opening

TMJ/Splint Therapy

Tired Jaw Muscles

Stiff Neck

Change in Bite

Stress

This is to certify that I, the undersigned, consent to dental procedures agreed to be necessary or advisable for myself or my child, including the use of local anaesthetic, or other drugs as indicated and will assume responsibility for fees associated with those procedures. As well, I allow Sunshine Dental Centre to share my personal information with other Health Care Professionals and Benefit Companies as necessary, in order to assist in providing the best care for me. For the safety purposes of clients and staff, some procedures may require full surgical gowning. I give consent for those involved in the dental procedure to put on any surgical/sterile attire if necessary.

NAME : Please print:

SIGNATURE :

DATE: