PARK DRIVE DENTAL CENTRE INC.
STOUFFVILLE, ON.

1. PERSONAL INFORMATION *(Please Print)*

DATE ____ / ____ / ____
D M Y

Name: ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr. _____
(GIVEN NAME) (FAMILY NAME)

Address: _____
(NUMBER) (STREET) (APT)

_____ _____ _____ Place of Birth _____
(CITY) (PROV) (POSTAL CODE)

Date of Birth: ____ / ____ / ____ Cell Phone: _____
D M Y

Home Phone: _____ Business _____ Ext. _____

Email: _____

Occupation: _____ Employer: _____

Referred by: _____

Person responsible for account: ❑ Self ❑ Other _____

Dental Insurance: ❑ Yes ❑ No If Yes, Insurance Name _____

Cert. ID#. _____ Group Policy No. _____

Reason for today's visit: ❑ Examination ❑ Emergency ❑ Other _____

Physician: _____ Telephone _____

In case of emergency please notify: _____

Relationship _____ Telephone _____

2. MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. *ALL INFORMATION IS CONFIDENTIAL.*

	YES	NO
1. Are you presently under the care of a physician?	❑	❑
2. Have you ever been hospitalized?	❑	❑
Specify: _____		
3. Do you have a heart or circulatory problem of any kind?	❑	❑
Specify: _____		
4. Have you ever had rheumatic fever?	❑	❑
5. Do you have any allergies?	❑	❑
Specify: _____		
6. Are you presently taking any kind of medication?	❑	❑
Specify: A) Drug _____ Reason _____		
B) Drug _____ Reason _____		
C) Drug _____ Reason _____		
7. Do you have a bleeding problem?	❑	❑
8. Are you pregnant?	❑	❑
9. Do you smoke?	❑	❑
10. Have you ever had a reaction to any kind of medicine?	❑	❑
Specify: _____		

C291710775

PARK DRIVE DENTAL CENTRE INC.
STOUFFVILLE, ON.

11. Do you presently have or have you ever had: *(Please ✔)*

❑ Anaemia	❑ Hemorrhage	❑ Rheumatism
❑ Arthritis	❑ High (Low) blood pressure	❑ Scarlet fever
❑ Asthma	❑ Hyper (Hypo) glycemia	❑ Stomach (Intestinal) ulcer
❑ Blood disorder	❑ Kidney disease	❑ Stroke
❑ Cancer	❑ Liver disease (i.e. Hepatitis)	❑ Thyroid problem
❑ Diabetes	❑ Lung disease	❑ Tuberculosis
❑ Epilepsy	❑ Mental or nervous disorder	❑ Venereal disease
❑ Hay Fever	❑ Migraine headaches	❑ AIDS

	YES	NO
12. Have you ever had a concussion?	❑	❑
13. Have you ever fainted?	❑	❑
14. Have you ever had any illness not included above?	❑	❑

Specify: _____

Medical Update _____

3. DENTAL HISTORY

1. How frequently do you see your dentist?
❑ 6 Months ❑ Yearly ❑ Other _____
Last dental visit _____
2. Have you ever been given oral hygiene instruction in:
❑ Brushing ❑ Flossing ❑ Other _____

3. Have you ever had local anaesthetic?	❑	❑
Any complications: _____		
4. Are any of your teeth sensitive to: ❑ Cold ❑ Sweets ❑ Heat ❑ Other _____		
5. Do your gums bleed when: ❑ Brushing ❑ Flossing ❑ Spontaneously		
6. Do your gums feel swollen or tender?	❑	❑
7. Does food catch between your teeth?	❑	❑
8. Are you aware of any loose teeth?	❑	❑
9. Have you ever had a full mouth series of dental x-rays?	❑	❑
10. Does your jaw crack, pop or grate when you open widely?	❑	❑
11. Do you grind or clench your teeth?	❑	❑

Dental Update _____

PATIENT CERTIFICATION AND APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Patient (Parent, Guardian) Signature _____ Date _____

PATIENT (PARENT/GUARDIAN) CONSENT (FOR MINORS)

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

Parent/Guardian Signature _____ Date _____