PATIENT INFORMATION (CONFIDENTIAL) DATE:________________

NAME:____ADDRESS:____

POSTAL CODE:_________________ CITY:______________HOME PHONE:_________________CELL:__________________

WORK:_____________________EXT._____DATE OF BIRTH:__________________AGE:____SEX:____MARITAL STATUS:____

EMAIL:____HEALTH CARD NO.:______________________________________

SPOUSE OR PARENT'S NAME:_________________________________EMPLOYER:_________________________________

EMERGENCY CONTACT NAME:_________________________________PHONE:____________________________________

NAME OF SCHOOL (IF STUDENT):_____________________________________GRADE:_____________________________

WHOM MAY WE THANK FOR REFERRING YOU:____

PLEASE INDICATE YOUR PERMISSION FOR THE FOLLOWING:

	YES	NO
-ALLOW EMAILS FROM PRACTICE	____	____
-APPOINTMENT REMINDERS BY EMAIL	____	____
-APPOINTMENT REMINDERS BY SMS	____	____
-MONTHLY NEWSLETTER	____	____
-ACCOUNT STATEMENTS	____	____

INSURANCE INFORMATION

NAME OF INSURED:____DATE OF BIRTH:________________________

EMPLOYER/GROUP POLICY HOLDER:________________________________INSURANCE COMPANY:____________________

PHONE:___________________________POLICY #:___________________________CERTIFICATE#:____________________

IF YOU HAVE ADDITIONAL INSURANCE PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED:_____________________________________ ______DATE OF BIRTH:____________________________

EMPLOYER/GROUP POLICY HOLDER:_____________________________INSURANCE COMPANY:______________________

PHONE:_____________________________________POLICY#:____________________CERTIFICATE#:___________________

PATIENT DENTAL HISTORY

Please note that prior to any treatment our office requires a complete dental and medical history. Knowing any health problems that you have and/or medications that you may be taking can avoid problems when treatment commences. Thank you for taking the time to answer these questions.

PATIENT'S NAME:____DATE:________________________________

REASON FOR THIS VISIT____

WHEN WAS YOUR LAST DENTAL VISIT? WHAT WAS DONE THEN?____

HOW FREQUENTLY DID YOU VISIT THE DENTIST BEFORE THEN?____

PREVIOUS DENTIST (NAME & LOCATION):____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL X-RAYS TAKEN? IF SO, WHEN?__________________________________

HOW OFTEN DO YOU BRUSH AND FLOSS YOUR TEETH?____

		YES	**NO**
1.	DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	___	___
2.	ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	___	___
3.	ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	___	___
4.	DO YOU FEEL DISCOMFORT/ PAIN WITH ANY OF YOUR TEETH?	___	___
5.	DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	___	___
6.	HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	___	___
7.	HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS WITH YOUR JAW?		
	-CLICKING OR GRINDING NOISES	___	___
	-PAIN (JOINT, EAR, SIDE OF FACE)	___	___
	-DIFFICULTY IN OPENING OR CLOSING	___	___
	-DIFFICULTY IN CHEWING	___	___
	-DO YOU CLENCH OR GRIND YOUR TEETH	___	___
8.	DO YOU HAVE FREQUENT HEADACHES?	___	___
9.	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	___	___
10.	HAVE YOU NOTICED ANY TEETH BECOMING LOOSE?	___	___
11.	DOES FOOD HAVE A TENDENCY TO BECOME CAUGHT BETWEEN YOUR TEETH?	___	___
12.	HAVE YOU EVER HAD PERIODONTAL (GUM) TREATMENT?	___	___
13.	HAVE YOU EVER HAD ORTHODONTIC TREATMENT (BRACES)?	___	___
14.	HAVE YOU EVER WORN A BITE PLATE, NIGHTGUARD, OR OTHER APPLIANCE?	___	___
15.	HAVE YOU EVER HAD DIFFICULTY WITH EXTRACTIONS IN THE PAST?	___	___
16.	HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	___	___
17.	DO YOU WEAR FULL OR PARTIAL DENTURES?	___	___
	-IF YES, DATE OF PLACEMENT________________________________		
18.	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	___	___
19.	DO YOU HAVE DRY MOUTH ISSUES?	___	___

MEDICAL HISTORY

PATIENT'S NAME:___________________________________DATE OF BIRTH:_________________________________

	YES	NO
- ARE YOU IN GOOD HEALTH? …………………………………………………………………………………………	___	___
- HAVE THERE BEEN CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR? ……………………………	___	___
- DATE OF YOUR LAST PHYSICAL EXAM____		
- PHYSICIAN'S NAME/PHONE NUMBER____		
- ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ………………………………………………………	___	___
- HAVE YOU EVER BEEN HOSPITALIZED FOR AN OPERATION OR SERIOUS ILLNESS? ……………………………	___	___
PLEASE EXPLAIN____		
- ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICATION? …………………	___	___
IF YES, WHAT MEDICINE(S) ARE YOU TAKING?____		
____		
____		
____		
- HAVE YOU EVER EXPERIENCED ABNORMAL BLEEDING? …………………………………………………………	___	___
- DO YOU BRUISE EASILY? ………………………………………………………………………………………………	___	___
- HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? ……………………………………………………………	___	___
- HAVE YOU HAD A RECENT WEIGHT LOSS? ………………………………………………………………………	___	___
- DO YOU USE TOBACCO? ………………………………………………-…………………………………………	___	___
- DO YOU OR HAVE YOU EVER USED CONTROLLED SUBSTANCES? …………………………………………………	___	___
- DO YOU HAVE ANY DISEASE, CONDITION, OR MEDICAL ISSUES NOT LISTED ABOVE THAT YOU THINK WE SHOULD BE AWARE OF? ……………………………………………………………………………	___	___

WOMEN ONLY:

	YES	NO
-ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? …………………………………………………	___	___
-ARE YOU NURSING? ……………………………………………………………………………………………	___	___
-ARE YOU TAKING BIRTH CONTROL PILLS? ………………………………………………………………	___	___

ARE YOU ALLERGIC OR HAVE YOU HAD REACTIONS TO:

	YES	NO
- LOCAL ANAESTHETICS OR FREEZING …………………………………………………………………………	___	___
- PENICILLIN OR OTHER ANTIBIOTICS …………………………………………………………………………	___	___
- BARBITUATES, SEDATIVES, OR SLEEPING PILLS ………………………………………………………………	___	___
- ASPIRIN (ASA) ………………………………………………………………………………………………	___	___
- IODINE ………………………………………………………………………………………………………	___	___
- LATEX/RUBBER ……………………………………………………………………………………………	___	___
- OTHER (PLEASE LIST)____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
- HEART DISEASE	___	___
- SCARLET/RHEUMATIC FEVER	___	___
- HEART DEFECT (HEART MURMUR/MITRAL VALVE PROLAPSE)	___	___
- HEART TROUBLE, HEART ATTACK, OR ANGINA/CHEST PAIN	___	___
- SHORTNESS OF BREATH	___	___
- PACEMAKER	___	___
- HEART SURGERY/STENTS/ANGIOPLASTY	___	___
- STROKE	___	___
- HIGH/LOW BLOOD PRESSURE	___	___
- CHOLESTEROL	___	___
- SWELLING OF FEET, ANKLES, HANDS	___	___
- HEPATITIS/JAUNDICE/LIVER DISEASE	___	___
- LUNG/BREATHING PROBLEMS/COPD	___	___
- TUBERCULOSIS	___	___
- PERSISTENT COUGH	___	___
- ASTHMA OR HAY FEVER	___	___
- HIVES OR SKIN RASH	___	___
- FAINTING OR DIZZY SPELLS	___	___
- DIABETES	___	___
- AIDS OR HIV INFECTION	___	___
- THYROID PROBLEMS	___	___
- ARTHRITIS OR RHEUMATISM	___	___
- JOINT REPLACEMENT OR IMPLANT	___	___
- BACK/SPINAL PROBLEMS	___	___
- OSTEOPOROSIS	___	___
- STOMACH ULCER	___	___
- KIDNEY TROUBLE	___	___
- CANCER	___	___
- TUMOURS/CYSTS	___	___
- SEXUALLY TRANSMITTED DISEASES	___	___
- EPILEPSY OR SEIZURES	___	___
- ANEMIA	___	___
- GLAUCOMA	___	___
- MENTAL HEALTH CARE	___	___
- CHEMICAL DEPENDENCY	___	___

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE ST. CLAIR DENTAL ASSOCIATES TO RELEASE INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION, (IN ACCORDANCE WITH **THE *PERSONAL HEALTH INFORMATION PROTECTION ACT 2004***), RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X____ ____

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE**