Packham Avenue Dental

Personal Information

Name:_____ M ___ F ___ Date of Birth:____/____/____ (D/M/Y)
Parents names (if patient is a minor):_____
Address: _____ City: _____ Postal Code: _____
Phone: (H) _____ (W) _____ (C) _____
Email: _____
Emergency Contact: _____ Phone: _____
Physician: _____ Phone: _____ Health Card # _____
How did you hear about our office? _____

Insurance Information

1st Insurance Company: _____ Policy # _____ ID # _____
2nd Insurance Company: _____ Policy # _____ ID # _____
Treaty Number _____

Medical Information

1. List all drugs (prescription, non-prescription, herbal) that you are presently taking or have recently taken:_____
2. Do you have any allergies? (please list) _____
3. Do you smoke or use chewing tobacco? (circle) YES NO
4. Do you have or had any of the following? (please check)

__ heart attack	__ stroke	__ HIV or AIDS	__ angina pectoris
__ stomach ulcers	__ arthritis	__ heart failure	__ chronic bronchitis
__ organ transplant	__ cancer	__ artificial joint	__ under-active thyroid
__ irregular heart beat	__ epilepsy	__ blood disease	__ overactive thyroid
__ tuberculosis	__ hepatitis	__ rheumatic fever	__ psychiatric disorder
__ liver impairment	__ seizure	__ emphysema	__ fainting spells
__ artificial heart valve	__ diabetes	__ heart defect	__ high blood pressure
__ bleeding disorder	__ pacemaker	__ medical implant	__ heart murmur

5. List any disability, condition or problem not listed above: _____
6. Are you pregnant or nursing? (circle) YES NO

Oral Health Information

1. What is your main concern about your mouth? _____
2. Are you nervous about dental treatment? (circle) YES NO
3. Have you had any of the following conditions/treatments? (please check)

__ dental implants	__ uncomfortable jaw	__ tooth whitening	__ root canal therapy
__ bleeding gums	__ jaw joint noises	__ gum surgery	__ crowns or bridges
__ loose teeth	__ jaw locking	__ dentures	__ TMJ (jaw joint) treatment
__ injured teeth	__ tooth extractions	__ clenching/grinding	__ ortho braces/appliances
__ tooth aches	__ sensitive teeth	__ oral surgery	__ oral piercings

4. When was your last complete exam by a dentist?_____
5. When was your last cleaning by a hygienist? _____

SIGNATURE: _____ **DATE:** _____