Welcome to our office!

Please complete both sides and return to the front desk

Patient Name: _____ Birth Date: _____ Age: _____
(mm/dd/yyyy)

Address: _____ Gender:_____

City: _____ Province: _____ Postal Code: _____

Home Phone:_____Cell Phone:_____ Work Phone:_____

E-mail Address: _____

Responsible Party Information: ☐ Same as above

Name: _____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

E-mail Address: _____

Referral Information:

1) How did you hear about us?

Dentist: _____ Friend: _____

Flyer: _____ Sign: _____

Online (circle all that apply): Google Facebook Instagram

2) Describe the reason for your visit today: _____

_____

3) Do you have Insurance Coverage? Single _____ Dual _____ None _____

I hereby authorize release of any information which pertains to the Treatment or Insurance Benefits for the above patient. I understand and agree that, regardless of my insurance status, I am responsible for the full payment of all services provided.

Patient/Parent Signature:_____ Date:_____
(if patient under 18 years old)

Medical / Dental Health

Dentist's Name: _____
How long has it been since your last dental visit? _____
Has a Panoramic X-Ray been taken in the last 12 months? _____
Is there any outstanding dental treatment: Yes_____No____ If yes, what_____

Has an Orthodontist been consulted previously? Yes_____ No_____
Does anyone else in your family have a similar issue? _____

Have any of the following habits been noticed? If stopped, please indicate the age you stopped.

Thumb or Finger Sucking_____ Snoring _____
Tongue Thrust_____ Grinding Teeth _____
Lip Biting _____ Nail Biting _____
Mouth Breathing _____ Other _____

Are any of the following conditions present or in past history?

	Yes	No		Yes	No
Allergies			Rheumatic Fever		
Heart Ailment, Cardiac surgery			High or Low Thyroid		
Heart Murmur			Dizziness		
Diabetes			Fainting		
Tonsillitis			Hepatitis or Jaundice		
Cold Sores or Blisters			High or Low Blood Pressure		
Asthma			Anemia		
Tuberculosis			Injuries to Face, Mouth, or Teeth		
Epilepsy or Seizures			HIV or AIDS		

● If you answered 'Yes' to any of the above, please specify: _____
_____

● Any other Medical Information or Medical Alerts we should be aware of? _____
_____

● Present general overall health: Excellent _____ Good _____ Fair _____ Poor _____

● Are you currently under a physician's care? Yes _____ No _____ If yes, what for?
_____

● Are you currently taking any drugs or medications? Yes ____ No ___ If yes, which and why?
_____

I certify that the information I have given is complete and to the best of my knowledge.

Patient/Parent Signature:_____ Date:_____
(if patient under 18 years old)