DENTAL INTAKE FORM

PATIENT INFORMATION

Name Gordon Lightfoot	**Birthdate** 1980-01-01
Address 123 Main Street Small Town, BC H0H0H0 Canada	

Cell Phone 555-555-1234	**Work Phone**	**Home Phone**

Email no-reply@clinicforms.co	**Drivers License #**
How did you hear about our office?	

EMERGENCY CONTACT

Name	**Phone**

FAMILY DOCTOR

Name Klein Bernhardt	**Phone** 555-555-4321

INSURANCE INFORMATION

Do you have insurance?	Yes

PRIMARY INSURANCE

Are you the policy holder?	No
Policy Holder Joe Smith	**Birthdate** 1950-01-01

Insurance Company	Manulife	**Employer**	Save on Foods
Policy #	123456	**Cert/ID #**	

Basic (A) %	80	**Major (B) %**	40	**Yearly Max**	20

SECONDARY INSURANCE

Are you the policy holder?	Yes		
Insurance Company	SunLife	**Employer**	Safeway
Policy #		**Cert/ID #**	

Basic (A) %	**Major (B) %**	**Yearly Max**

MEDICAL HISTORY

This information is necessary for your dental care and will remain confidential.

Are you currently under the care of a physician due to a specific medical condition? No	**Are you taking any prescription or non-prescription medications?** Yes

Please list the medication and reason for the medication

Medication	Reason
Tylenol	Headaches

Are you allergic to or have had an adverse reaction to any medications? Yes

Please select the medication that you are allergic to or had a reaction to

- [ ] Aspirin
- [ ] Barbiturates
- [ ] Codeine
- [ ] Erythromycin
- [ ] Local Anesthetic
- [x] Penicillin
- [ ] Sulfa
- [ ] Valium
- [ ] Other

Have you ever been warned against taking any other medications? No	**Do you suffer from any allergies (hay fever, latex, etc.)?** No

Do you bruise easily or have prolonged bleeding? No

Do you smoke or use tobacco products? Yes	**How much per day?** 2
Are you pregnant? No	

Do you have or have you ever had any of the following?

- [ ] Artificial Joints
- [x] Artificial Heart Valve
- [ ] Blood Disorder
- [x] Cancer
- [ ] Diabetes
- [ ] Emphysema
- [ ] Heart Disease
- [ ] Heart Surgery
- [ ] Heart Murmur
- [ ] Hepatitis A B C
- [ ] High Blood Pressure
- [ ] HIV Positive (AIDS)
- [ ] Kidney Disease
- [ ] Low Blood Pressure
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] STD
- [ ] Migraines
- [ ] Radiation/Chemotherapy TX
- [ ] Rheumatic Fever
- [ ] Mental/Nervous Disorder
- [ ] Stroke
- [ ] Thyroid Disease

Do you have any disease, condition, or problem not listed?

DENTAL HISTORY

What is the reason for today's visit?
Shortness of breath

How frequently do you see a dentist?
Annually

When was your last dental visit?
Less than 1 year

When was your last dental X-Ray?
1 to 2 years

How often do you brush?
Weekly

How often do you floss?
Not Applicable

Are your teeth sensitive to

- [X] Cold
- [ ] Sweets
- [ ] Heat
- [ ] Other

Do your gums bleed when

- [ ] Brushing
- [ ] Flossing
- [ ] Never

Do you grind or clench your teeth?
No

Are you satisfied with the way your teeth feel?
No

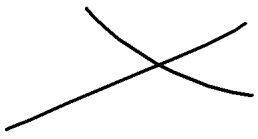
Have you ever had any problems with previous dental treatments? Please explain

What, if anything, would you change about your smile?

CONSENT

✔ I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care providers as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine the necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature



Relationship to patient
Self