DENTAL INTAKE FORM

PATIENT INFORMATION

Name Johanna Mary Johnson			**Date of Birth** 23/12/2020
Marital Status Married	**Gender** Female	**Height (cm)** 1.7 cm	**Weight (kg)** 100
Address 123 Main Street Colorado City, St John's MMM555 Cambodia			
Phone (Home) 555-999-7777	**Phone (Work)** 666-333-5555	**Phone (Cell)** 666-999-1111	
Email ildikopap@yahoo.ca			
✔ I consent to receiving regular emails regarding my oral health			
✔ I give you consent to leave a detailed message on my voicemail.			
Occupation Carpenter		**Employer** Kitchen Cabinets etc	
Family Physician John Smith		**Dentist** Gordon Ramsay	
Are you seeing a dental specialist other that us? (Ortho, perio, endo)		Yes	
Name of specialist Dr. Elizabeth Swanson			
Do you live alone?		Yes	

EMERGENCY CONTACT

Name Kenneth Branagh	**Phone** 555-999-7777

FOR PRESCRIPTION PURPOSES

OHIP / RAMQ 123456	**Driver's License** 546874

HEALTH QUESTIONNAIRE

Are you in good health?	Yes
Are you presently having pain or difficulty with your teeth or your jaw?	Yes

Explanation
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Are you on any medications?	Yes

Medications

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Do you have any known allergies?
Yes

Allergies

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Do you Smoke or vape?	Yes
How many per day? 2	**How many years?** 3
Have you ever had abnormal bleeding tendencies?	Yes

Have you been treated in the past for:

- [X] Diabetes
- [ ] Epilepsy
- [ ] Rheumatic Fever
- [X] Asthma
- [ ] Hypertension
- [ ] Heart Trouble
- [ ] Kidney Disease
- [ ] Hepatitis
- [ ] HIV+

Have you ever been diagnosed with:

- [X] Lung Problems (Asthma, Emphysema, Bronchitis, other)
- [ ] Problems with your immune system (HIV/AIDS, steroid use, Lupus)
- [ ] Osteoporosis (used drugs like / Médicaments: Fosam, Actonel, Aredia, Zometa)
- [ ] Stroke
- [X] Cancer (Chemotherapy, Radiation Therapy)
- [ ] Other

Do you snore?	Yes	**Do you stop breathing when you sleep?**	Yes
Have you ever been diagnosed with Sleep Apnea?	Yes	**Do you use a CPAP machine?**	Yes

Do you currently, or have you in the past, used prescription narcotics, street drug or marijuana recreationally? Yes

Recreational Narcotics, Drugs or Marijuana Usage

What	How much	How often
Speed	12 gms	1Xday

Are you now or have you ever been treated for drug addiction or alcoholism?	Yes	**Are you subject to neurological disorders? (Multiple sclerosis, Parkinson's Alzheimer's, etc.)**	Yes

Have you ever had General Anesthetic? Yes

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Have you or your family ever had complications during an anesthetic?	Yes	**Do you have dizziness or shortness of breath?**	Yes

Is there anything special about you or your family's physical condition that should be called to the doctor's attention? Yes

Please explain
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Are you pregnant?	Yes	**Do you wear contact lenses?**	Yes	**Are you highly afraid of needles?**	Yes

How did you hear about us?
Other

Signature