w: essentialdentistry.ca
e: info@essentialdentistry.ca
p: 403-938-2749
f: 403-938-3674

PERSONAL INFORMATION

Name: _____Date:_____

Address: _____ City: _____Prov:_____PC_____

Phone Res: _____Cell:_____Bus:_____E-mail:_____

DOB: _____Gender: M___F___O___ Marital Status: M__ S___O___Occupation:_____

Person responsible for account: _____Phone: _____

Physician: _____Phone:_____Date of last medical examination: _____

Previous Dentist: _____Phone: _____Date of last dental examination: _____

Whom may we thank for referring you? _____

HEALTH INFORMATION

Please add any necessary explanation to your answers.

Is your physician treating you now? _____Y N

To the best of your knowledge are you in good health? _____ Y N

Have you ever had a serious illness? _____ Y N

Are you currently experiencing a persistent cough, undiagnosed skin rash or diarrhea? _____Y N

Are you presently taking any medications or supplements? _____ Y N

Are you hypersensitive or allergic to any medications or drugs? _____Y N

Have you ever been hospitalized? _____ Y N

Have you had any previous surgery? _____Y N

Do you currently use any tobacco or cannabis products? _____Y N

Are you a current or past recreational drug user? _____Y N

Have you gained or lost excessive weight recently? _____Y N

Have you ever taken cortisone or steroids? _____Y N

Have you or a relative ever had had adverse reaction to local or general anaesthetic? _____Y N

Are you presently pregnant or nursing? _____ Y N

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Please circle any of the follow conditions that you currently suffer from or have in the past:

Abnormal bleeding	Cancer	Hepatitis	Lung problems	Rheumatic Fever
Abnormal bruise	Diabetes	High blood pressure	Low Blood pressure	Sinusitis
Allergies	Dizziness	Hip replacement	Migraines	Stroke
Anemia	Epilepsy	HIV	Multiple Sclerosis	Swollen ankles
Arthritis	Fainting	Jaundice	Muscular Dystrophy	Thyroid disease
Asthma	Headaches	Knee replacement	Nervous tension	Tuberculosis
Blood disorders	Heart disease	Kidney disease	Psychiatric care	Ulcers
Breathlessness	Heart murmur	Liver disease	Radiation therapy	Venereal disease

Details about any of your circled answers:

_____

_____

DENTAL INFORMATION

Do you have any sensitive teeth? _____Y N
Do you experience jaw pain or clicking in the jaw? _____ Y N
Do you have any areas where food gets caught? _____Y N
Is there anything you'd like to change about the colour or shape of your teeth? _____Y N
Are you aware of any dental treatment that has been recommended but not completed? _____ Y N
Have you ever had orthodontic treatment? _____Y N
Describe your current routine for taking care of your teeth? _____ Y N
Anything you'd like us to know before beginning today's appointment? _____Y N

POLICIES and CONSENT

- ☐ I hereby certify that the Medical and Dental History is accurate and complete to the best of my knowledge.
- ☐ I consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anaesthtetic or any drugs indicated.
- ☐ I assume responsibility for any and all fees associated with those procedures. Payment is due when services are rendered and will be accepted in the form of dental insurance benefits (when secured by a credit card), credit card or debit card. Any financial arrangements must be made prior to treatment.
- ☐ An administration fee will be charged for missed or cancelled appointments with less than 2 business days' notice.
- ☐ I consent to electronic communication (email and/or text messages) with Essential Dentistry. I understand that I may opt out of such communication at any time.

Signature: _____Date: _____