Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. PLEASE PRINT.

MEDICAL ALERT

Today's Date___________________________________

PERSONAL INFORMATION Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑

Last Name: ____DOB: ____________________

Given Names: ____Sex: ❑ M ❑ F

Address: ____

City / Town:_________________________________ Prov:__________ Postal Code: ______________

Home Phone #: ________________ Cell Phone #: ________________ Work Phone #: ________________

E-mail Address: ____

May we use this email for appointment reminders, financial and office communications? Yes ❑ No ❑

Emergency Contact: ______________________________ Relationship: ________________________

Phone #: ____________________Work#_____________________Cell # _____________________

Family physician:____ Phone #: _________________

Whom may we thank for referring you or how did you hear about our office? ________________________

INSURANCE INFORMATION Do you have dental insurance? ❑ Yes ❑ No

1. Name of primary carrier: ___________________________ Policy holder's name: ____________________

Group #:____________ ID or Certificate #: ________________ DOB of Policy holder: ____________________

2.Name of secondary carrier: _________________________ Policy holder's name: ____________________

Group #:____________ ID or Certificate #: ________________ DOB of Policy holder: ____________________

PATIENT / GUARDIAN CONSENT *Accounts not paid in a timely manner will be switched to nonassignment accounts.

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. I understand that I am financially responsible for all fees associated with those procedures whether or not paid by my insurance company. I hereby authorize Dental Elements to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependents dental care.

APPOINTMENT AND CANCELLATION POLICY

Our office requires 48 hours notice to change or cancel appointments or a cancellation fee may be applied. Missed appointments may result in suspension of future dental services and/or dismissal.

Patient/Guardian Signature____Date ____________________

The following information is required by the dentist to assist in proper diagnosis and treatment. ALL INFORMATION IS CONFIDENTIAL.

MEDICAL HISTORY

Yes No

1. Have you ever had a serious illness or are you under the care of a physician now? ❑ ❑
2. Have you had a medical exam in the last year? ❑ ❑
3. Do you use medicine now? ❑ ❑

   If yes, please specify ____________________
4. **Do you require any premedication prior to your dental visit?** ❑ ❑
5. Do you have any allergies? ❑ ❑
6. Do you have or have you ever had any of the following? (please check ✔)

   ❑ Heart murmur or mitral valve prolapse ❑ Stomach/intestinal problems ❑ Joint replacement (hip, knee, etc.) ❑ Mental or nervous disorder ❑ High/low blood pressure ❑ Hyper (hypo) glycemia ❑ Epilepsy or seizures

   ❑ Asthma ❑ Any lung disease ❑ Thyroid disease ❑ Arthritis or rheumatism ❑ Scarlet or rheumatic fever ❑ Drug/alcohol addiction

   ❑ AIDS ❑ Positive testing for HIV virus ❑ Jaundice ❑ Diabetes ❑ Tuberculosis ❑ Stroke

   ❑ Hepatitis A/B/C ❑ Herpes ❑ Heart attack ❑ Cold sores ❑ Cancer ❑ Kidney disease ❑ Sinus trouble

   ❑ Liver Disease ❑ Cortisone/ steroid therapy ❑ M.S. ❑ Lupus ❑ Other ____________
7. Have you ever experienced any unusual reaction to any of the following drugs?

   ❑ Aspirin ❑ Barbituates ❑ Sulfonamide ❑ Local anesthesia

   ❑ Acetaminophen ❑ Codeine ❑ Penicillin
8. Have you ever used tobacco? ❑ Yes ❑ No If yes, how much / day? ________ For how long? ________

Yes No

9. Are you diabetic? ❑ Yes ❑ No Any family history of diabetes? ❑ ❑

   If yes, how is your diabetes control? Good ❑ Fair ❑ Poor ❑
10. Are you currently dealing with any stressors (death of a spouse, divorce/separation, death in the family, injury/illness, retirement, loss of job, jail term, other)? ❑ ❑
11. Do you consider your stress level high? ❑ ❑
12. Do you find it hard to eat a balanced diet? ❑ ❑
13. Do you bruise easily or abnormally? ❑ ❑
14. Do you have any blood disorders such as anemia (thin blood)? ❑ ❑
15. Have you ever had any injury, surgery or radiation therapy to your face or jaws? ❑ ❑
16. Do you have a prosthesis? (Artificial hip, artificial heart valve, etc.) ❑ ❑
17. Do you have any disease, condition or problem not listed above that you think the Doctor should know about? ❑ ❑

    If yes, please explain ____________________
18. Have you taken cocaine in the last 6 months? (normal freezing combined with cocaine can be fatal) ❑ ❑
19. Have you ever been tested for HIV? ❑ ❑

    When:____________ Result: ____________
20. WOMEN ONLY — Are you pregnant? (how many weeks?) ____________ ❑ ❑

DENTAL HISTORY

Yes No

1. Have you had x-rays in the last year? ❑ ❑
2. When was your last dental exam?____________
3. Have you ever had any teeth extracted? ❑ ❑
4. Were there any complications involved? ❑ ❑
5. Have you ever had any complications from anesthetic? ❑ ❑
6. Do any of your teeth ache? ❑ ❑
7. Do your gums bleed when you brush? ❑ ❑
8. Do you have any loose teeth? ❑ ❑
9. Do your gums feel tender or swollen? ❑ ❑
10. Does food catch between your teeth? ❑ ❑
11. Have you ever had a bad dental experience? ❑ ❑
12. Do you have any current dental concerns? ❑ ❑
13. Is condition due to an accident? ❑ ❑

    Please note any concerns, fears, or past experiences that our dental office should be aware of, so we can make your visits here comfortable? ____________