Pre-Clinical History

Today's Date: _____

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you. Thank you!

ABOUT YOU

Name: _____ □ Female □ Male
Address: _____
City: _____ Prov.: _____ Postal Code: _____
Home Phone: _____ Bus. Phone: _____
Cell Phone: _____
Birth Date: Day_____Month_____ Year_____
□ Single □ Married □ Widowed □ Minor
E-mail Address: _____
Name of Spouse: _____
Name of Children: _____
Health Card #: _____
Who can we thank for referring you: _____

EMERGENCY INFORMATION

Person to Contact: _____
Relationship: _____
Phone: _____

INSURANCE INFORMATION

□ No Insurance Coverage.
□ I will be responsible for all charges to my dental account.
□ I have alternative dental coverage.

Insurance Company Name: _____
Group#: _____ID#: _____
SIN #: _____
Employer: _____
Name of School or University if applicable: _____
If spouse is your policy holder or has second insurance:
Spouse's Name: _____
Spouse's Birth date: ____/____ /____ Spouse's SIN#: _____
Spouse's Employer: _____

DENTAL HISTORY

How do you feel your overall dental health is:
□ Excellent □ Good □ Fair □ Poor
Rate how regularly you have had your teeth cleaned:
□ 9 months □ 6 months □ 3 months □ Unknown
What is your level of sensitivity to dental procedures:
□ Low □ Moderate □ High
How do you feel about the look of your teeth:
□ Excellent □ Good □ Fair □ Poor
Date of your last hygiene visit____ /____ /____
Are you interested in having regular hygiene cleanings? □ yes □ no
Have you ever been treated for TMJ or TMJD? □ yes □ no

What is the main reason for your visit today? _____
_____

UPPERGAGE DENTAL CENTRE
www.uppergagedental.ca

OVER →

MEDICAL HISTORY

Name of Physician: _____
Address: _____ Phone Number: _____

Have you had any serious health problems in the last five years? □ yes □ no If yes, please explain: _____

Do you smoke? □ yes □ no □ quit
(For Women) Are you currently pregnant? □ yes □ no
Have you ever needed an antibiotic before a dental appointment? □ yes □ no

Please list prescription/supplemental medications: _____
_____

Please check if you're allergic to any of the following

□ Local anesthetics
□ Penicillin/other antibiotics
□ Barbiturates, sedatives, sleeping pills
□ Sulfa drugs
□ Aspirin
□ Shellfish, iodine or red wine
□ Codeine/other narcotics
□ Latex sensitivity
□ Other _____
_____

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

□ AIDS/HIV Positive
□ Alzheimer's Disease
□ Anaphylaxis
□ Arthritis/Gout
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Breathing Problem
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Cold Sores/Fever Blisters
□ Congenital Heart Disorder
□ Convulsions
□ Cortisone Medicine
□ Diabetes
□ Drug Addiction
□ Easily Winded
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/Dizziness
□ Frequent Cough
□ Frequent Diarrhea
□ Frequent Headaches
□ Genital Herpes
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure
□ Heart Murmur
□ Heart Pace Maker
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High Blood Pressure
□ Hives or Rash
□ Hypoglycemia
□ Irregular Heartbeat
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Lung Disease
□ Mitral Valve Prolapse
□ Pain in Jaw Joints
□ Parathyroid Disease
□ Psychiatric Care
□ Radiation Treatments
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Spina Bifida
□ Stomach/Intestinal Disease
□ Stroke
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Venereal Disease
□ Yellow Jaundice
□ ADD/ADHD
□ Depression
□ Anxiety Disorders

Have you ever had any serious illness not listed above? If yes, please explain: _____
_____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Upper Gage Dental Centre.
I agree that Upper Gage Dental Centre can collect, use and disclose personal health information about myself as set out in the information about the office privacy's policies.

Signature _____ Date_____