BONNIE DOON DENTAL CLINIC

PATIENT INFORMATION

Date: _____

* Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

Name: Dr. ( ) Mr. ( ) Mrs. ( ) Miss ( ) Ms. ( )

_____
Last First Middle

Age: _____ Date of Birth: _____ Sex: _____ Marital Status: _____
DAY MONTH YEAR

Address: _____
Street City Prov. (State) Postal Code (Zip)

Home Phone: _____ Cellular Number, if applicable: _____

Occupation: _____ Employed By: _____

Business Phone: _____ Can We Call Anytime? ( ) Yes ( ) No

Email Address, if applicable: _____

Dental Insurance ( ) Yes ( ) No Name of Company: _____

Insurance Policy No. _____ % Covered: _____

S.I.N. _____ Health Insurance Number: _____

Driver's License Number: _____

Family Physician: _____ Phone No: _____

Previous Dentist: _____ Phone No: _____

Whom May We Thank for Referring You? _____

In Case of Emergency Notify: Name: _____

Address: _____

Relationship: _____ Telephone No: _____

Person Responsible for Account/Payments: (If under 18 years old)

Name: _____
Last First

Address: _____

Telephone: _____

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for the time lost.

Office policy is that services are paid for at each visit as they are performed. Any outstanding balances for any treatment rendered are the sole responsibility of the patient's whether they have insurance or not.

CONFIDENTIAL MEDICAL HISTORY

1. Date of last physical examination ..... Date: _____
2. Are you presently under the care of a physician? ..... ( ) Yes ( ) No
   Please specify: _____
3. Are you presently taking any pills, drugs or medication? ..... ( ) Yes ( ) No
   Please specify: _____
4. Have you taken any prolonged medication in the past? Prescription or Non-Prescription? ..... ( ) Yes ( ) No
   Please specify: _____
5. Have you had rheumatic fever, heart disease, or heart murmurs? ..... ( ) Yes ( ) No
6. Do you become breathless easily? ..... ( ) Yes ( ) No
7. Have you had abnormal bleeding after previous extractions, surgery or trauma? ..... ( ) Yes ( ) No
8. Have you taken cortisone or steroids? ..... ( ) Yes ( ) No
9. Have you any allergies? ..... ( ) Yes ( ) No
10. Have you allergies to any drugs or medicines: ..... ( ) Yes ( ) No
    i.e. Penicillin. Please specify: _____
11. Have you ever been hospitalized and was surgery performed? ..... ( ) Yes ( ) No
    Please specify: _____
12. Have you gained or lost excessive weight recently? ..... ( ) Yes ( ) No
13. Have you ever had radiation or X-ray therapy? ..... ( ) Yes ( ) No
14. Do you have or have you had? Please circle:

High Blood Pressure	Anemia	Herpes / Cold Sores	Sinus Problems	Over the Counter
Low Blood Pressure	Arthritis	Cancer	Stroke	Medication / Drugs
Thyroid Problems	Epilepsy	Psychiatric Care	Tuberculosis	
Heart Trouble	Diabetes	Venereal Disease	Ulcer	
Chest Pain	Liver Trouble	Scarlet Fever	Fainting Spells	
Hepatitis	Asthma	Kidney Trouble	Blood Disorders	
HIV Positive	Aids	Herbal Medicine	Recreational Drugs	

15. Do you smoke? ..... ( ) Yes ( ) No
    If so, how much?
16. Are you currently in good health? ( ) Yes ( ) No If not, please specify: _____
17. Is there anything else you think you should tell me? ..... ( ) Yes ( ) No
18. **If applicable**, are you pregnant? ( ) Yes ( ) No If so, how many weeks or months? _____

CONFIDENTIAL DENTAL HISTORY

1. Are you having any discomfort at this time? ..... ( ) Yes ( ) No
   Please specify: _____
2. Have you been under regular care by a dentist? ..... ( ) Yes ( ) No
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Have you ever been given local anaesthetic (freezing)? ..... ( ) Yes ( ) No
   Have you ever been given general anaesthetic? ..... ( ) Yes ( ) No
6. Any complications with #5? ..... ( ) Yes ( ) No
   Please specify: _____
7. Are you aware of any lump or swelling in your mouth? ..... ( ) Yes ( ) No
   If yes, where? _____
8. Are you satis ed with the appearance of your teeth? ..... ( ) Yes ( ) No
9. Are you anxious to keep your natural teeth? ..... ( ) Yes ( ) No
10. Describe in your own words what you would like done with your teeth.

    _____
11. Do you currently experience: (circle the appropriate ones)

Loose teeth	Bleeding gums	Sore or swollen gums
Sensitive teeth	Bad breath	Popping or clicking in the jaw joints
Ear ache	Neck pain	Missing teeth
Headache	Unexplained nosebleed	Gagging
Spaced or crooked teeth	Unsatisfactory dentures	

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (parent's) Signature: _____ Date: _____