Confidential Patient Information

Dr. Bill Cooke

Mr. / Mrs./ Ms. / Mstr./Miss/Dr.

Name _____ Birth Date *(dd/mm/yy)* _____/_____/_____

Address _____

City _____ Province _____ Postal Code _____

Home phone (_____)_____ Alternate phone (_____)_____

E-mail address *(for appointment reminders only)* _____

Financially responsible party's name *(parent/legal guardian)* _____

Relationship to patient _____

Address *(if different from above)* _____

City _____ Province _____ Postal Code _____

Home phone (_____)_____ Alternate phone (_____)_____

Employer or School _____

Occupation _____ How long? _____

Address _____

City _____ Province _____ Postal Code _____

Phone (_____)_____

Name of nearest relative not living with you *(emergency contact)* _____

Relationship to patient _____

Address _____

City _____ Province _____ Postal Code _____

Home phone (_____)_____ Alternate phone (_____)_____

Whom may we thank for referring you to our office? _____

Insurance Information

It is the responsibility of the PATIENT to provide accurate and up-to-date insurance information.

First Policy

Insured's name _____ Insured's date of birth *(dd/mm/yy)* _____/_____/_____

Insured's employer _____ Insurance company _____

Policy number _____ ID number _____

Additional Policies

Insured's name _____ Insured's date of birth *(dd/mm/yy)* _____/_____/_____

Insured's employer _____ Insurance company _____

Policy number _____ ID number _____

This is to certify that I consent to the performing of the dental procedures agreed to be necessary or advisable, and I will assume responsibility for all fees associated with the procedures. I also consent to the release of relevant personal information regarding my dental care.

Patient (Parent) signature _____ Date *(dd/mm/yy)* _____/_____/_____

In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. All information provided is strictly confidential. Although some questions may seem unimportant at the moment, they may be vital in case of emergency. Therefore, PLEASE ANSWER EVERY QUESTION.

I. Medical History

YES NO

What is your medical doctor's name? _____ Phone: _____

1. Are you under the care of a medical doctor at this time? _____ _____
2. Have you had a medical examination in the past year? _____ _____
3. Are you taking any medications or drugs at the present time? (Please list below) _____ _____

_____

_____

4. Have you ever had or been treated for (please circle or name if not listed):

heart trouble	rheumatic fever	liver disease	hepatitis
abnormal blood pressure	arthritis	thyroid disease	diabetes
cancer	epilepsy	anemia	gall bladder
tuberculosis	HIV/AIDS	blood disorders	anxiety disorders
psychiatric care	muscular dystrophy	multiple sclerosis	hearing disorder
sinusitis	gastrointestinal disease	sexually transmitted disease	

other _____

5. Do you have asthma, hay fever, hives or skin rashes? _____ _____
6. Any known allergies to medicine or other irritants? (please list below) _____ _____

_____

_____

7. Have you ever been warned against taking medicine or drugs or local anesthetic? _____ _____
8. Have you ever experienced any of the following? (please circle)

fainting	shortness of breath	chest pains	swelling in ankles or feet
unexplained weight loss	increase in thirst	increase in appetite	increased frequency of urination
Bruising easily	abnormal bleeding		

9. Is there any family history of disease or illness? _____ _____
10. To the best of your knowledge, are you in good health? _____ _____
11. Women Only: Are you pregnant? _____ _____

If "yes" what term of pregnancy? _____

II. Dental History

YES NO

1. Have you ever had a complete dental examination with a full series of x-rays of your jaws and teeth? _____ _____
2. When was your last dental exam? _____ _____
3. Have you had any teeth extracted due to abscess, accident, decay or gum disease? _____ _____

   If yes, have you had any prolonged bleeding after an extraction? _____ _____
4. Have you ever had root canal treatment, periodontal (gum) treatment, orthodontics, fixed bridges, caps, partial or full dentures? _____ _____
5. Are you tense during dental visits? _____ _____
6. Are you conscious of bad breath or a bad taste in your mouth? _____ _____
7. Do you chew easily and thoroughly? _____ _____
8. Do you favour one side when chewing? _____ _____
9. Are you satisfied with the appearance of your teeth and smile? _____ _____
10. Do you want to keep your natural teeth? _____ _____
11. Do you consider your teeth beyond treatment? _____ _____
12. Have you ever had a facial or head injury? _____ _____
13. Do you breathe through your mouth or do you snore? _____ _____
14. If you could change anything about your smile, what would it be?

_____

_____