Patient Information

Date: _____

Patient's Name: ❑ Ms. ❑ Miss ❑ Mrs.
❑ Mr. ❑ Dr. _____
(Last Name) (Given Name)

Birthdate _____ / _____ / _____ / Age _____
Day Month Year

Home Address _____
(Street)

_____
(Street)

_____
(City) (Postal Code)

Home Phone (_____) _____

Occupation _____

Employer _____

Office Phone (_____) _____

Cell Phone (_____) _____

Business Address _____

_____

_____

Spouse / Partner's Name (if applicable) _____

Occupation _____ Employer _____

Your Dentist _____ City _____

Phone# (_____) _____ How Long _____

Previous Dentist _____ City _____

How Long _____

Dental Specialist(s) _____ City _____

Your Physician _____

Office Location _____

Date of Last Complete Physical Exam _____

Findings _____

Medical Specialist(s) _____ Phone# (_____) _____
(Name & Specialty)

Dental Insurance Co. _____ Group, Policy, or Division No. _____

ID # / Cert _____ Dependent # _____

Are you covered by more than one dental plan? _____ Yes _____ No

Second Dental Insurance Co. _____ Group, Policy, or Division No. _____

ID # / Cert _____ Dependent # _____

North Burnaby Dental Group

PATIENT HEALTH HISTORY

How would you describe your general health? ❑ poor ❑ fair ❑ good ❑ excellent

DO YOU HAVE OR HAVE YOU EVER HAD? Circle any yes answers and explain below

1. Treatment from a physician within the last year ..... yes
2. Hospitalization for illness or surgery? ..... yes
3. Changes in your general health in the past year? ..... yes
4. A family history of serious disease? ..... yes
5. An allergy or reaction to:
   - Antibiotics ..... yes
   - Codeine ..... yes
   - Novocaine or other dental anesthetics ..... yes
   - Other drugs or medications: ..... yes
6. Heart disease (murmur, angina, heart attack, stroke, prosthetic valve or cardiac pacemaker)? ..... yes
7. Arteriosclerosis? ..... yes
8. High blood pressure? ..... yes
9. Low blood pressure? ..... yes
10. Excessively swollen ankles? ..... yes
11. A stroke? ..... yes
12. Shortness of breath on mild exertion? ..... yes
13. Chest pains on mild exertion? ..... yes
14. Rheumatic Fever? ..... yes
15. Do you require antibiotics before surgery or dental appointments? ..... yes
16. Hepatitis, liver disease, jaundice ..... yes
17. Cancer, a tumor or abnormal growth treated by radiation or chemotherapy? ..... yes
18. Prostate disorders (if male)? ..... yes
19. Stomach or duodenal ulcer? ..... yes
20. Fainting spells, convulsions or epilepsy? ..... yes
21. Arthritis, sore joints or rheumatism? ..... yes
22. Kidney disease? ..... yes
23. Diabetes? ..... yes
24. Excessive urinating? ..... yes
25. Recent weight loss unintentionally (with good appetite)? ..... yes
26. Chronic fatigue? ..... yes
27. Chronic diarrhea? ..... yes
28. Antibodies to HIV ..... yes
29. Venereal disease? ..... yes
30. Lung trouble (TB, asthma, emphysema)? ..... yes
31. Hives, skin rash, hay fever? ..... yes
32. Thyroid or parathyroid disorders? ..... yes
33. Anemia or other blood disorders? ..... yes
34. Prolonged bleeding due to slight cut ..... yes
35. Sores, swellings, or blisters on your gums, cheeks, or lips? ..... yes
36. Bleeding gums? ..... yes
37. Trenchmouth (St. Vincent's Disease, A.N.U.G.)? ..... yes
38. A dental or periodontal abscess? ..... yes
39. Do you clench or grind your teeth? ..... yes
40. A vision problem? ..... yes
41. Glaucoma? ..... yes
42. Do you wear contacts or eyeglasses? ..... yes
43. Do you have any artificial joints? ..... yes
44. Do you smoke? ..... yes
45. Do you regularly use alcohol? ..... yes
46. Do you regularly use non-prescription drugs? ..... yes
47. Have you used aspirin within the last week? ..... yes
48. Do you feel your eating habits are not adequate? ..... yes
49. Are you subject to frequent headaches? ..... yes
50. Have you had a nervous breakdown, or undergone psychotherapy or counseling? ..... yes
51. If female, are you now:
    - Pregnant? ..... yes
    - Using hormones (including birth control pills)? ..... yes
    - Going or having gone through menopause? ..... yes
52. List all prescription and non-prescription medication taken regularly:

_____

_____

_____

_____ _____

Patient Signature **Date**

PLEASE EXPLAIN ANY "YES" ANSWERS

_____

_____

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_____

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