NAME: _____ RES TEL: _____ BUS TEL: _____

ADDRESS: _____ CELL #: _____

CITY/PROV: _____ POSTAL CODE: _____ DATE OF BIRTH: _____

SEX: M ___ F ___ REFERRED BY: _____ PHYSICIAN'S NAME: _____ TEL: _____

DENTAL INSURANCE: YES __ NO __ IF YES, NAME OF INS CO: _____ _____

SOCIAL INSURANCE #: _____ PLACE OF EMPLOYMENT: _____

YOUR EMAIL ADDRESS: _____

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

1. Are you currently under the care of a physician? ..... Yes ____ No____
2. Have you ever been hospitalized? ..... Yes ____ No____
3. Do you have any heart or heart valve problems of any kind? ..... Yes ____ No____
   Specify: _____
4. Have you ever had rheumatic fever or heart murmurs? ..... Yes ____ No____
   Specify: _____
5. Are you presently taking any kind of medication? ..... Yes ____ No____
   Specify: A) Drug ..... Reason .....
   B) Drug ..... Reason .....
   C) Drug ..... Reason .....
6. Do you have or have you ever had a bleeding problem? ..... Yes ____ No____
7. Have you ever taken cortisones or steroids? ..... Yes ____ No____
8. Have you ever had a reaction to any kind of medicine ..... Yes ____ No____
   Specify: _____
9. Are you pregnant or suspect that you are? ..... Yes ____ No____
10. Do you presently have or have you ever had:

| | | |
|---|---|---|
| Allergies | Diabetes | Mental or nervous disorder |
| Anemia | Epilepsy | Pacemaker |
| Angina | Fainting spells | Shortness of breath |
| Arthritis | Glaucoma | Stroke |
| Artificial Joints or Valves | High/low blood pressure | Thyroid problem |
| Asthma | Hyper/Hypo glycemia | Tuberculosis |
| Blood disorder | Kidney disease | Ulcers or stomach problems |
| Cancer | Liver disease (e.g. Hepatitis) | STD's |
| Aids | Lung disease | Osteoporosis medications |

11. Have you ever had any illness not included above? ..... Yes ____ No____
12. Have you ever fainted? ..... Yes ____ No____

DENTAL HISTORY

1. How frequently do you see your dentist: 6 months____ yearly____ other____ Last dental visit _____
2. How often do you brush: _____ floss: _____
3. Have you ever had local anesthetic: ..... Yes ____ No____
   Any complications: _____
4. Are any of your teeth sensitive to: cold____ sweets____ heat_____ other_____
5. Do your gums bleed when: brushing_____ flossing_____ spontaneously_____
6. Do your gums feels swollen or tender? ..... Yes ____ No____
7. Do you catch food between your teeth..... Yes ____ No____
8. Are you aware of any loose teeth..... Yes ____ No____

AUTHORIZATION FOR TREATMENTS

I, the undersigned, hereby consent to receive all dental and surgical treatments deemed necessary, including the use of local anesthetics. Furthermore, I assume the full responsibility for the payment of all fees covering the aforementioned treatments. I hereby assign my benefits payable from claims submitted electronically to the Dentist and authorize payment directly to him/her.

**PLEASE NOTE: ALL WHITENING PROCEDURES MUST BE PAID FOR PRIOR TO TREATMENT!**

Patient's signature (Parent's): _____ Date: _____