South Rock
DENTAL

Welcome to South Rock Dental. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any recent changes in your health, please tell us. If you have any questions, don't hesitate to ask.

**I. PERSONAL HISTORY:**

Patient Name: _____

Date of Birth: _____ Sex: Male/Female

Address: _____

Postal code: _____ City: _____ Province: _____

Home Phone: ( ) - _____ Cell: ( ) - _____

Email: _____

How did you hear about our office: _____

Do you have dental insurance: Yes / No _____

**II. DENTAL HISTORY:**

Former dentist: _____Date of Last dental visit and treatment provided? _____

How often do you brush your teeth? _____ Floss? Y / N Do your gums bleed? Y / N

What dental conditions concern you at present? _____

_____

Please check **(√ )** if you have or have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Are your teeth sensitive to hot, cold, sweet, sour? | | Do you feel pain in any of your teeth? | | Do you have any sore or lumps in/near your mouth? | | Have you had any head, neck or jaw injuries? | |
| Do you have any of the following problems with your jaw? Clicking, pain, difficulty opening, closing or chewing? | | Do you have severe headaches or frequent headaches? | | Do you clench or grind your teeth? | | Do you bite your lips/cheeks frequently? | |
| Does food get caught between your teeth? | | Have you had difficult extractions | | Have you had prolonged bleeding after an extraction? | | Injury, surgery or radiation to face/jaw | |

Do you wear dentures or partials? If yes, placement date? _____

Do you have dental implants? If yes, placement date? _____

Have you had orthodontic treatment? If yes, date of completing? _____

Have you had treatment from a dental specialist? If yes, what type? _____

**III. MEDICAL HISTORY:**

Please check **(√ )** if you have or have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rheumatic Fever | | Fainting spells | | Stomach/intestine issues | | Artificial valves, joints | |
| Heart murmur | | Severe headaches | | Kidney/bladder problems | | Diabetes | |
| Congenital heart condition | | Stroke | | Hepatitis | | Neck or back injuries | |
| High blood pressure | | Asthma/trouble breathing | | Blood disorders | | Codeine/Demerol/ Narcotics allergy | |
| Low blood pressure | | Sinus trouble | | Tumours/growths/cancer | | Aspirin/Acetaminophen/ Ibuprofen allergy | |
| Angina (chest pain) | | Thyroid | | Jaundice/liver disease | | Seizures/Epilepsy | |
| Heart attack | | Arthritis | | Tendency to faint | | Penicillin/Antibiotic allergies | |
| Heart surgery | | Cortisone/steroid therapy | | Premedication required by a physician | | Pacemaker | |

| | Y | **N** | **Please List:** |
|---|---|---|---|
| Are you currently under the care of a physician for a specific ailment? | | | |
| Are you currently taking any medications? If yes Please list: | | | |
| Any other allergies? LATEX, SULPHA DRUGS, LOCAL ANESTHETIC | | | |

| **FOR WOMEN ONLY:** | **Y** | **N** |
|---|---|---|
| Are you taking any contraceptives or other hormones? | | |
| Are you pregnant? If yes, when is your expected delivery date? | | |

**OFFICE POLICY:**

We require **48 hours notice** for appointment changes. There is a charge for missed appointments and short cancellations. The patient portion of fees is due at the time of service. We will accept direct assignment from your insurance company but if for any reason they reject the claim or do not pay the full amount, you remain financially responsible for the balance. Claims to insurance not paid within eight weeks will be billed to the patient.

**CONSENT FOR TREATMENT:**

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

Date: _____ Signature: _____

If parent or guardian please print name: _____