WELCOME TO OUR DENTAL OFFICE

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

PERSONAL INFORMATION

Name : ____

Last First Middle

Date of Birth: ____________________ **Age:** ___________ Male ☐ Female ☐

Address: ____

Street Unit # City Province Postal Code

Phone Number: _________________ _________________ _________________________

Home Work Cell

Parent /Guardian Name _____________________________**Phone:** ________________

In case of emergency, notify ________________ **Phone**_________________________

E-mail: ____

Whom may we thank for the referral? ____

DENTAL HISTORY

How often do you visit the dentist? 3M☐ 4M☐ 6M☐ 9M☐ Other________________________

How often do you brush your teeth? _________________

How often do you floss your teeth? ________________________

Have you ever had any problems with previous dental treatment? ___________________________________

Have you ever experienced any jaw (TMJ) problems?

Popping ☐ Clicking ☐ Pain ☐ Limited Opening ☐ Other__________________________

Do you clench or grind? Yes ☐ No☐

Are you satisfied with appearance of your teeth? Yes☐ No☐

Former Dentist____________________ Last Dental Visit________ Last Dental Cleaning____________

DENTAL INSURANCE? Yes ☐ No ☐

If "Yes", please provide the front desk with your insurance information.

MEDICAL HISTORY

1. Are there any changes to your medical history? .... Yes□ No □
2. Are you in good health? .... Yes□ No □
3. Are you currently under the care of a physician?.. Yes□ No □
4. Have you been hospitalized in the past two years?... Yes□ No □
5. Do you have an allergy to: penicillin, sulfonamide, aspirin or any other medications? Yes□ No □
   If "Yes" list the any other medication: ....
   ....
6. Do you have any other allergies? (Hay fever, skin rash, food, etc.)? .... Yes□ No □
7. Do you have a heart murmur or mitral valve prolapse? .... Yes□ No □
8. Have you had an organ transplant or **joint replacement?** .... Yes□ No □
   If "Yes "please state when:...
9. Do you have high blood pressure?.. Yes□ No □
10. Do you have a disease, medical condition, or problem that is not listed ?............................. Yes□ No □
    If "Yes" please specify: ....
11. Do you have heart disease?... Yes□ No □
12. Do you have thyroid disease?... Yes□ No □
13. Do you have diabetes? .... Yes□ No □
    If "Yes", please state whether it is Type I or Type II: ....
14. Have you been diagnosed with cancer?.. Yes□ No □
15. Have you had any cortisone or steroid therapy?.. Yes□ No □
16. Do you have Hepatitis A, B or C?.. Yes□ No □
    If "Yes", please state which type: ....
17. Do you have AIDS or have tested positive for H.I.V.?.. Yes□ No □
18. Do you smoke? If"Yes", please state how often?... Yes□ No □
19. Do you have or have you had any of the following? Please check:

□ Chest pain(angina)	□ Rheumatic fever	□ Pacemaker	□ Steroid therapy	
□ Seizures(epilepsy)	□ Osteoporosis	□ Stroke	□ Lung disease	
□ Heart attack	□ Kidney disease	□ Arthritis	□ Tuberculosis	□ Other

20. Is there anything else concerning your health that the doctor should know about?

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FAMILY PHYSICIAN: ______________________________ **Phone number :**__________________________________

PESCRIBED MEDICATIONS:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

PATIENT RELEASE

I certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I will inform Dr. Boudakian of any changes that may occur in the future regarding my health or prescribed medications.

_______________ ____________________________________ _________________________

Date **Signature** (of parent/guardian if younger than 18) **Reviewing Dentist Date**