Today's Date: _____ Health Card Number: _____

The data on this confidential questionnaire is essential to render the best professional care. We would appreciate your co-operation in filling out this sheet carefully, so that we will have accurate records. THANK YOU.

Name (in full)_____ Telephone: Home:_____

Telephone: Cell:_____ Email Address: _____

Address _____ Apt._____ City_____ Postal Code _____

Date of Birth _____ Marital Status _____

Occupation_____ Business Telephone _____

Employer _____ Address _____

Your Husband's/Wife's: Given Name _____

Occupation _____ Business Telephone _____

Employer _____ Address _____

Do you have Dental Insurance? ❑ Yes ❑ No

If yes, name of company _____

Policy/Group Number _____ ID/Certification Number _____

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

Do you have or have you ever had any of the following (mark appropriate conditions):

- ❑ heart condition / heart murmer
- ❑ stomach/intestinal problems
- ❑ joint replacement (hip, etc.)
- ❑ high/low blood pressure
- ❑ epilepsy or seizures
- ❑ hepatitis A/B
- ❑ drug addiction
- ❑ lung disease
- ❑ arthritis/rheumatism
- ❑ bleeding disorders
- ❑ dental implants
- ❑ diabetes
- ❑ tuberculosis
- ❑ stroke
- ❑ heart attack
- ❑ herpes
- ❑ cancer
- ❑ kidney disease
- ❑ sinus trouble
- ❑ liver disease
- ❑ AIDS or immunodeficiencies
- ❑ cortisone/steroid
- ❑ asthma
- ❑ serious operations
- ❑ thyroid disorder
- ❑ mitral valve prolapse
- ❑ glaucoma
- ❑ anemia
- ❑ angina
- ❑ artificial heart valve
- ❑ rheumatic fever
- ❑ are you pregnant now
- ❑ birth control pills

Have you ever had excessive bleeding requiring special treatment? ❑ Yes ❑ No

If so, explain _____

Have you ever fainted? ❑ Yes ❑ No _____

Do you have drug allergies:

to Penicillin?	❑ Yes	❑ No	to Sulfa?	❑ Yes	❑ No
to Codeine?	❑ Yes	❑ No	to Local Anaesthetic?	❑ Yes	❑ No
to Aspirin?	❑ Yes	❑ No	to any other drugs?	❑ Yes	❑ No

Do you have other allergies? ❑ Yes ❑ No _____

Name of physician _____ Telephone _____

When was your last physical examination? _____

When was your last dental examination?_____

Are you now under treatment by a physician? ❑ Yes ❑ No

Explain _____

Are you taking any drugs regularly? ❑ Yes ❑ No

Please list: _____ _____ _____ _____

_____ _____ _____ _____

Is there anything concerning your physical or mental condition or your previous dental visits that the doctor should know?

❑ Yes ❑ No Explain _____

_____

Please turn over