Today's Date: _____ Health Card No. _____

**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 _____

Address _____ Apt. _____ City _____ Postal Code _____

Date of Birth _____ Year _____

Father's Name _____ Cell No. _____

Occupation _____ Business Telephone _____

Employer _____ Address _____

Mother's Name _____ Cell No. _____

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

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*