Welcome to Ajax Family Dentistry

1. ABOUT YOU

Today's Date: _____

Name: ☐ MR ☐ MRS ☐ MS ☐ DR

_____ _____ _____
FIRST MIDDLE LAST

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ S.I.N.: _____

Home Address: _____

_____ _____ _____
CITY PROVINCE POSTAL CODE

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: _____ Cell #: _____

Work #: _____ Ext: _____

Employer: _____

Employer's Address: _____

How long there?: _____ Occupation: _____

Where & when are best times to reach you?: _____

How did you find out about our office?: _____

Other family members seen by us: _____

Previous Dentist: _____

Last Visit Date: _____

2. SPOUSE INFORMATION

Spouse's Name: _____

Employer: _____

Work #: _____ Ext.: _____

Birthdate: _____ S.I.N.: _____

Person Responsible For Account: _____

Work #: _____ Ext: _____ Home #: _____

Relationship: _____ Employer: _____

Billing Address: _____

_____ _____ _____
CITY PROVINCE POSTAL CODE

3. DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Plan, Local or Policy #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's S.I.N.: _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Plan, Local or Policy #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's S.I.N.: _____

Insured's Employer: _____

4. DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

_____

_____

Are you currently in pain?	☐ No ☐ Yes ☐ Extremely
Have you ever had a serious / difficult problem associated with any previous dental work?	☐ No ☐ Yes
Have you ever had braces or any orthodontic treatment?	☐ No ☐ Yes
Have you ever had any gum surgery (Periodontal work)?	☐ No ☐ Yes
Do you now or have you ever experienced pain or discomfort in your jaw joints muscles of the face?	☐ No ☐ Yes
Are you interested in whitening your teeth or improving the appearance of your smile?	☐ No ☐ Yes
Do your gums ever bleed?	☐ No ☐ Yes

How many times a day do you brush? _____ Floss? _____

5. MEDICAL HISTORY

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ☐ No ☐ Yes

Please list each one: _____

FOR WOMEN: Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week # _____

Are you nursing? ☐ No ☐ Yes

Have you ever had any of the following diseases or medical problems? (Please check if yes)

- ☐ Heart Attack / Stroke
- ☐ Heart Surgery / Pacemaker
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Congenital Heart Defect
- ☐ Mitral Valve Prolapse
- ☐ Artificial Valves
- ☐ Artificial Bones / Joints
- ☐ Arthritis
- ☐ Fainting Spells
- ☐ HIV+ / AIDS
- ☐ Sinus Problems
- ☐ Shingles
- ☐ Radiation Treatment
- ☐ Cancer / Chemotherapy
- ☐ Hospitalized for Any Reason
- ☐ Psychiatric Problems
- ☐ Epilepsy / Seizures
- ☐ Diabetes
- ☐ Drug / Alcohol Abuse
- ☐ Ulcers / Colitis
- ☐ Venereal Disease
- ☐ Kidney Problems
- ☐ Hepatitis
- ☐ Asthma / Difficulty Breathing
- ☐ Tuberculosis
- ☐ Fever Blisters
- ☐ Anemia / Blood Transfusion
- ☐ Hemophilia / Abnormal Bleeding
- ☐ Emphysema / Glaucoma
- ☐ Severe / Frequent Headaches
- ☐ High / Low Blood Pressure

☐ Check here if NO to all of above

Please list any serious medical conditions that you have ever had:

_____

Are you Allergic to any of the following? (Please check if yes)

- ☐ Penicillin
- ☐ Erythromycin
- ☐ Codeine
- ☐ Tetracycline
- ☐ Dental Anesthetics
- ☐ Aspirin
- ☐ Latex
- ☐ Other

☐ Check here if NO to all of above

Please list any other drugs that you are allergic to:

_____

_____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Work #: _____ Home #: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to preform any necessary dental services with my informed consent that I may need during diagnosis and treatment

_____ _____

SIGNATURE DATE

Payment us due in full at the time of treatment unless prior arrangements have been approved

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at that time, please ask us. We are happy to help.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein: Initials _____ Date _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____
4. Date _____ Comments _____ Signature _____