



Name* _____ Last Name* _____

Preferred Name _____ Middle Name _____ Title _____

Address* _____

City* _____ Province* _____ Postal Code* _____

Birth Date (yyyy-mm-dd)* _____ Gender* Male Female

Marital Status* Single Married Widowed Divorced Common-Law Separated

Home # _____ Work # _____ Work # Ext _____

Email Address* _____

Best Contact* Home Work Cell Email

Emergency* _____ Emergency Contact #* _____

Do you have dental insurance?* Yes No

MEDICAL INFORMATION

Name* _____ Last Name* _____

Physician's Name* _____

Location* _____ Physician's Phone # * _____

Are you taking any pills, drugs, medications or herbal supplements? * Yes No

Do you have prescription allergies?* Yes No

Do you have any allergies?* Yes No

Do you have a latex allergy?* Yes No

Do you have a reaction to Epinephrine?* Yes No



- Do you have a problem with local anesthetic?* Yes No
- Do you have any history of health conditions?* Yes No
- Do you take Bisphosphonates? (for Osteoporosis)* Yes No
- Are you currently pregnant or breast feeding?* Yes No
- Do you have any infectious diseases?* Yes No
- Do you have any respiratory diseases?* Yes No
- Do you have any heart conditions?* Yes No
- Have you required antibiotics for dental treatment in the past?* Yes No
- Do you have diabetes?* Yes No
- Do you take blood thinners?* Yes No
- Do you require special attention for any of the following?* Yes No
- Have you been hospitalized or had any surgery in the past 5 years?* Yes No

I certify that the above Health History has been completed to the best of my knowledge. I understand that this information will be kept confidential. *

I agree

Signature* _____