PATIENT INTAKE FORM

NAME: ____ **DOB** _______________________________________

ADDRESS: ____

POSTAL CODE: ____________________ **EMAIL:** ____

FAMILY DOCTOR: ___________________________________ **GENDER:** ______________________________________

HOME PHONE: ____________________________________ **MOBILE:** ____

MEDICAL HISTORY

CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU

Heart Failure	Artificial Joint	Thyroid Disease	Liver Disease
Heart Disease/Attack	Anemia	X-ray/Cobalt	Yellow Jaundice
Angina Pectoris	Kidney Trouble	Chemotherapy	Blood Transfusion
High Blood Pressure	Ulcers	Arthritis	Drug Addiction
Heart Murmur	Emphysema	Rheumatism	Hemophilia
Rheumatic Fever	Tuberculosis	Cortisone Medicine	Venereal Disease
Congenital Heart Lesions	Persistent Cough	Glaucoma	Cold Sores
Scarlet Fever	Asthma	Pain in Jaw Joints	Genital Herpes
Artificial Heart Valve	Hay Fever	AIDS	Epilepsy/Seizures
Heart Pacemaker	Sinus Trouble	Hepatitis A (Infectious)	Fainting/Dizzy Spells
Heart Surgery	Allergies/Hives	Hepatitis B (serum)	Nervousness
Stroke	Diabetes	Hepatitis C	Psychiatric Treatment
Sickle Cell Disease	Bruise Easily		

Do you have any disease, condition or problem not listed? __________________________________

Have you been under hospital/Doctor care in the last two years? ____________________________

Are you allergic to any medication? Which? ____

Do you get shortness of breath/pain in your chest/very tired when walking up stairs? __________

Do your ankles swell during the day? ____

Following injuries, have you ever had bleeding problems? __________________________________

Are you a smoker? _______________ **Are you allergic to latex?** ____________________________

Have you ever had an allergic reaction to local anesthesia? (Dental freezing) ________________

Are you nervous about having dental treatment? ____________

Do your gums bleed when brushing your teeth? _____________

Are you dissatisfied with your teeth and their appearance? ________________

Date of last dental exam ___________________________

Women: Are you pregnant now or anticipate becoming pregnant? ___________________________

Reason for today's visit: _________________________________

Can you provide a current list of medications

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures

Patient/Guardian Signature ________________________________ **Date** _____________________