# Eastport Dental Centre - Confidential Patient Record

Patient _____
Surname First Middle

Date of Birth _____ Age _____
Day Month Year

Address _____

City _____ Postal _____ Email _____

Home Phone _____ Work _____ Cell _____

Occupation _____ Employer _____

Family Doctor _____ Phone _____ Emerg. Contact _____

How did you hear about us? (circle) Postcard Welcome Wagon Walk By (big sign) Yellow Pages Website
Friend/Family Referral (name) _____
Other (please specify) _____

## DENTAL INSURANCE INFORMATION

**Insurance Company #1** _____
Policy/Group # _____
ID # _____
Policy Holder's Name _____
Policy Holder's Birth date _____
Policy Holder's Employer _____

**Insurance Company #2** _____
Policy/Group # _____
ID # _____
Policy Holder's Name _____
Policy Holder's Birth date _____
Policy Holder's Employer _____

## MEDICAL HISTORY

1. Are you currently in good health? ☐yes ☐ no
   If no, please explain _____
2. Are you currently taking any medications or vitamins (prescription, over-the-counter, recreational)? ☐yes ☐ no
   If yes, please list _____
3. Do you currently smoke? ☐yes ☐ no If yes, for how long _____
4. Are you allergic to or ever had a reaction to any of the following: (please circle)
   Penicillin Local Anesthetic ("freezing") Sulfa Drugs
   Codeine Aspirin (ASA) Other _____
5. Are you under the regular care of a physician? ☐yes ☐ no
   If yes, please explain _____
6. Do you bleed more or longer than normal after a cut, bruise, surgery or previous tooth removal? ☐yes ☐ no
7. Have you ever had a serious illness or operation? ☐yes ☐ no
8. Do you currently have or ever had any of the following conditions? (please circle)
   Heart Trouble or Stroke Heart Murmur Thyroid Disorder Rheumatic Fever
   Breathing Problems Arthritis HIV Positive Tumors or Cancer
   High/Low Blood Pressure Hepatitis Liver Disease Kidney Disease
   Mental Illness Diabetes Tuberculosis Epilepsy or Seizure
   Blood Disorders Venereal Disease Hormonal Disorder Other: _____
9. Women: Are you pregnant? ☐yes ☐ no If yes, which trimester? _____
10. Is there anything else we should know about your health? ☐yes ☐ no
    If yes, please explain _____

## DENTAL HISTORY

11. What dental condition(s) concern you at present? _____
12. When was your last dental check-up and cleaning? _____
13. Were X-rays taken at your last dental visit? ☐yes ☐ no
14. When was the last time you changed **dental offices**? _____
15. Have you noticed any signs of the following? (please circle)
    Bleeding Gums Swelling of Gums Gum Ache Receding Gums Loose Teeth Drifting of Teeth
16. Do you have any clicking, popping or pain in your jaw joint? ☐yes ☐ no
17. Are you aware of clenching or grinding your teeth? ☐yes ☐ no
18. Do you have any missing teeth that you feel should be replaced? ☐yes ☐ no
19. Would you like to improve the appearance of your teeth? ☐yes ☐ no
20. Do you floss your teeth? ☐yes ☐ no How often? _____
21. Have you had any complications or difficulty with previous dental treatment? ☐yes ☐ no
22. How do you rate yourself as a dental patient? ☐ Calm ☐ Slightly Nervous ☐ Very Anxious

I hereby certify that the Medical and Dental Histories provided are accurate and complete to the best of my knowledge. I 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 or any drugs as indicated and I will assume responsibility for fees associated with those procedures.

Date _____ Signature _____