

# Patient Information

DATE \_\_\_\_\_

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

Patient Name: \_\_\_\_\_  
Last First Middle

Name of Spouse: \_\_\_\_\_  
Last First Middle

Phone: \_\_\_\_\_  
Res. Bus. Ext.

Address: \_\_\_\_\_  
Street City Prov. Postal Code

E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of birth: \_\_\_\_\_  
Day Month Year Gender

Family Doctor: \_\_\_\_\_  
Phone

Contact for appts: \_\_\_\_\_  
Name Relationship Phone

Dental Insurance?  Yes  No

Please provide your insurance information/card with policy / ID# to one of our receptionists.

Health Card #: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Person responsible for account: \_\_\_\_\_

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it will be necessary to charge for the time lost.

Office policy is that services are paid for at each visit as they are performed. However in certain circumstances arrangements for payment may be made by consulting your dentist.

## **CONFIDENTIAL DENTAL HISTORY**

1. Are you having any discomfort at this time? .....  Yes  No

Please specify \_\_\_\_\_

2. Have you been under regular care by a dentist? .....  Yes  No

3. How long since your last dental visit? \_\_\_\_\_

4. What was done at that time? \_\_\_\_\_

5. Do your gums feel tender and swollen? .....  Yes  No

6. Are you aware of any lump or swelling in your mouth? .....  Yes  No

7. Are you satisfied with the appearance of your teeth? .....  Yes  No

8. Are you tense during dental visits? .....  Yes  No

9. Do you currently experience: (*circle the appropriate one*)

loose teeth	bleeding gums	sore gums	gagging
sensitive teeth	bad breath	popping or clicking in jaw joints	unsatisfactory dentures
ear ache	neck pain	headache	
unexplained nosebleed	missing teeth	spaced or crooked teeth	