East Credit Dental Center
5100 Terry Fox Way
P. 905.997.6453
F. 905. 567.5207
E. office@99smile.ca

Patient Information

Last Name ________________________________ First Name _____________________________________

Address ____ Apt. ______________________

City ______________________________________ Province __________ Postal Code _________________ ___

E-mail Address ____

Home Ph. ( ) __________________ Bus. Ph. ( ) __________________ Cell Ph. ( ) __________________

Date of Birth _______ /_______ /__________ ❏ Male ❏ Female Marital Status _____________________

DD MM YYYY

Occupation _______________________________ Employer ____

Emergency Contact ________________ Tel. No. ( ) __________________ Relationship __________________

Whom may we thank for referring you to our office? ____

Dental Insurance Information

Person responsible for financial matters: ❏ Self ❏ Spouse ❏ Parent/Guardian

If different from above, please complete the following:

Last Name ________________________________ First Name ____

Address ____ Apt.________________________

City ______________________________________ Province __________ Postal Code _________________ ___

E-mail Address ___________________ ____

Home Ph. ( ) _________________ Bus. Ph. ( ) __________________ Cell Ph. ( ) __________________

Medical History Information

Family Physician ____ Tel. No. ( ) _________________

1. Date of last visit to your physician _______ /_______ /__________For what purpose?
_____________________DD MM YYYY

2. Generally, are you in good health? .... Yes ❑ No ❑

3. Have you ever had a serious illness or been hospitalized? .... Yes ❑ No ❑

If so, please explain ____

4. Are you taking any prescription drugs, over the counter medications or herbal remedies?

Drug _______________________________ Dosage _________ Reason _________________________________

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Drug _______________________________ Dosage _________ Reason _________________________________

Drug _______________________________ Dosage _________ Reason _________________________________

5. Have you ever had an allergic reaction or adverse effect to any of the following:

❑ Aspirin ❑ Codeine ❑ Penicillin ❑ Sulfonamide ❑ Sleeping pills ❑ Local anaesthetic

6. Do you suffer from any allergies to the following:

❑ Latex ❑ Metals ❑ Food ❑ fever ❑ Other__________________________

7. Do you bruise easily or have prolonged bleeding? .... Yes ❑ No ❑

8. Do you smoke? If so, how much? .... Yes ❑ No ❑

9. Have you ever fainted, had shortness of breath or chest pains? .... Yes ❑ No ❑

10. WOMEN: Are you pregnant? .... Yes ❑ No ❑

Are you taking birth control pills? .... Yes ❑ No ❑

11. Do you have or have you ever had any of the following?

❑ Aspirin
❑ AIDS / HIV
❑ Herpes
❑ Hepatitis A/B/C
❑ Venereal Disease
❑ Epilepsy
❑ Stroke
❑ Anemia
❑ Sickle Cell Anemia
❑ Leukemia
❑ Angina
❑ Lung Disease
❑ Artificial Heart Valve
❑ Eating Disorder
❑ Mental/Psychiatric Disorder
❑ Mitral Valve Prolapse
❑ Artificial Joints (hips/knees)
❑ Organ Transplant/Implant
❑ Arthritis
❑ Asthma
❑ Blood Disorder
❑ Radiation / Chemotherapy

❏ Bronchitis
❏ Heart Murmur
❏ Emphysema
❏ Rheumatic/Scarlet Fever
❏ Ulcers
❏ Hodgkin 's disease
❏ Cancer
❏ Glaucoma
❏ Kidney Disease
❏ Sickle Cell Disease
❏ Thyroid Problem
❏ Hyper/Hypo Glycemia
❏ Diabetes
❏ Head/Neck Injuries
❏ Osteoporosis
❏ Sinus Trouble
❏ Tuberculosis Liver Disease
❏ Other ___________________________
____
❏ Drug/Alcohol Dependence
❏ Stomach/Intestinal Problem
❏ Jaundice
❏ High/Low Blood Pressure

Dental History Information

Previous Dentist ____ Tel. No. ( ) __________________

1. Date of last visit to your dentist _______ /_______ /__________ For what purpose? _____________ ________

DD MM YYYY

2. What is the reason for today's visit? ❏ Emergency ❏ Examination ❏ Other ___________________________

3. How frequently do you see a dentist? ❏ 3-6 months ❏ Annually ❏ Other ___________________________

4. When was your last dental visit? ________________________Last dental x-rays ________________ _________

5. How often do you brush per day? _________ Floss ________Use antibacterial mouth rinse ________ ______

6. Are your teeth sensitive to: ❏ Hot ❏ Cold ❏ Sweets ❏ Other

7. Do your gums bleed when: ❏ Brushing ❏ Flossing ❏ Never

8. Have you ever had any of the following treatments?

❏ Bridgework ❏ Crowns or Caps ❏ Full or Partial Dentures

❏ Orthodontic (Braces) ❏ Periodontal/Gum Surgery ❏ Root Canal

9. Do your gums feel swollen or tender? .... Yes ❏ No ❏

10. Do you have bad breath or a bad taste in your mouth? .... Yes ❏ No ❏

11. Do your jaws crack, pop or snap when you open widely? .... Yes ❏ No ❏

12. Do you get food caught between your teeth? .... Yes ❏ No ❏

13. Do you grind or clench your teeth? .... Yes ❏ No ❏

14. Have you ever had any complications with local anesthetic (freezing).. Yes ❏ No ❏

15. Have you ever had any problems with a dental treatment? .... Yes ❑ No ❑

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

17. What would you like to change, if anything? .... Yes ❑ No ❑

GENERAL RELEASE: I, the undersigned, understand that the information contained in the dental and medical history portion of this chart is important to my treatment.

I certify that all the information is correct and that I have not knowingly omitted any information. I consent to the release of medical information from my medical doctor

or other health provider as required by Village Dental. I authorize Village Dental to perform diagnostic procedures as may be required to determine necessary treatment.

I assume all responsibility for fees associated with my dental treatment and/or dental diagnostic procedures.

Patient's Signature ____ Date ______ /______ /________