DENTISTRY
ON ROCHMAN

PATIENT INFORMATION

MR.MRS. MISS MS. OTHER	LAST NAME	FIRST	INITIAL	☐ MALE ☐ FEMALE	DATE OF BIRTH (M/D/Y)
ADDRESS					
CITY/PROVINCE					POSTAL CODE
TELEPHONE RESIDENCE		BUSINESS		CELLULAR	
EMAIL					
OCCUPATION		EMPLOYER			
PERSON INSURED		RELATIONSHIP TO INSURED			
EMERGENCY CONTACT NAME				TELEPHONE	

MEDICAL HISTORY

PHYSICIAN'S NAME	TELEPHONE
MEDICAL SPECIALIST (If presently under care)	TELEPHONE
ARE YOU PRESENTLY OR HAVE YOU BEEN UNDER A DOCTOR'S CARE IN THE LAST 2 YEARS? WHY?	
ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR HAVE YOU TAKEN ANY MEDICATIONS IN THE LAST 2 YEARS? PLEASE LIST THEM HERE:	

Please check YES or NO. If not sure, check NS		YES	NO	NS
Have you ever been diagnosed with any heart disease?				
Have you ever had a heart attack?				
Have you ever been diagnosed with angina?				
Have you ever had any blood pressure problems?				
Have you ever had rheumatic fever?				
Have you ever been diagnosed with hepatitis A/B?				
Have you ever had any breathing difficulties?				
Have you ever had any kidney or liver disease?				
Have you ever been diagnosed with diabetes?				
Have you ever had any stomach/digestive problems?				
Have you ever been diagnosed with any psychiatric disorder?				
Have you ever had any serious operations?				
Have you had a positive testing for HIV virus?				
Have you ever had AIDS or AIDS related problems?				
Have you ever had any tumors or cancer?				
Have you ever been diagnosed with epilepsy?				
Are you allergic to anything (including latex)?				
Are you allergic to any drugs, especially the following (please circle)? Penicillin, Local anaesthesia, Aspirin, Barbiturates, Codeine, Iodine, Sulfa				
Do you have any artificial joints, heart valves, pacemaker or other prosthetic implants?				
Do you bleed abnormally (particularly after extractions)?				
Do you smoke or use any other forms of tobacco (including transdermal patch)?				
Do you consume any alcohol or recreational drugs?				
Is there anything not mentioned that the dentist should be aware of?				
WOMEN ONLY	Are you pregnant? How many months _____			
	Are you nursing?			

DENTAL HISTORY

WHAT IS THE REASON FOR TODAY'S VISIT?	
WHEN WAS YOUR LAST DENTAL VISIT? WHAT WAS IT FOR?	
PREVIOUS DENTIST	ADDRESS AND TELEPHONE

Please check YES or NO. If not sure, check NS	YES	NO	NS
Are you nervous about having dental treatment?			
Have ever had an upsetting experience in a dental office or any complications during or following dental treatment?			
Are you suffering from any sort of pain/discomfort now?			
Do you grind or clench your teeth?			
Are you satisfied with the appearance of your teeth?			
Do you notice any clicking/popping of the jaw when opening/closing?			
Do you notice any bleeding from your gums when you brush your teeth, or other?			
Do you have any difficulty with chewing?			
Have you had toothbrushing instructions or have been shown how to floss your teeth?			
Have you had orthodontic treatment (braces)?			
Have you had any oral surgery?			
Have you had any periodontal treatment (gum surgery)?			

MISCELLANEOUS

WHOM MAY WE THANK FOR REFERRING YOU?	ARE OTHER FAMILY MEMBERS PATIENTS AT OUR OFFICE? NAMES:
HOW WOULD YOU PREFER TO BE CONTACTED (e.g., email, home telephone, cellular telephone) AND WHAT TIME OF DAY?	

FINANCIAL

Person responsible for account	SELF ☐	SPOUSE ☐	OTHER ☐
NAME (LAST)	(FIRST)	(INITIAL)	TELEPHONE
ADDRESS			
EMPLOYER			TELEPHONE
Method of payment	CASH ☐	CHEQUE ☐	CREDIT CARD ☐ OTHER ☐

Primary Dental Insurance			
SUBSCRIBER NAME	D.O.B.	I.D./S.I.N.	
INSURANCE COMPANY	TELEPHONE	GROUP POLICY NUMBER	
Insurance year end:	Maximum Coverage:		
% COVERAGE: Basic	Major Restorative	Ortho.	Other Other

Secondary Dental Insurance			
SUBSCRIBER NAME	D.O.B.	I.D./S.I.N.	
INSURANCE COMPANY	TELEPHONE	GROUP POLICY NUMBER	
Insurance year end:	Maximum Coverage:		
% COVERAGE: Basic	Major Restorative	Ortho.	Other Other

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT:

PATIENT/PARENT/GUARDIAN _____ DATE _____ DENTIST _____ DATE _____