## WELCOME TO OUR OFFICE – SUNSHINE DENTAL CENTRE

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All answers will be considered confidential. Thank you.

## ABOUT YOU

| | | |
|---|---|---|
| Name : | | Preferred Name : |
| Address : | | |
| City : | Province : | Postal Code : |
| Home Phone : | Business Phone : | Cell Phone : |
| Birthdate : M/D/Y | Male/Female : | Occupation : |
| E-Mail : | | |
| Emergency Contact : Name/Phone # : | | |
| **Would you prefer (please circle):** | Appointment Confirmations via: | Text / Email / Phone |
| | Emailed Statements: | yes / no |

## FINANCIAL INFORMATION

### PRIMARY INSURANCE

| | |
|---|---|
| Policy Holder : | Relationship to Holder : |
| Insurance Company : | Group/Policy # : |
| Employer : | SIN# : |
| Policy ID/Certificate # : | Policy Holder Birthdate : |

### SECONDARY INSURANCE

| | |
|---|---|
| Policy Holder : | Relationship to Holder : |
| Insurance Company : | Group/Policy # : |
| Employer : | SIN# : |
| Policy ID/Certificate # : | Policy Holder Birthdate : |

*This is to certify that all of the information that I, the undersigned, have provided is complete and accurate.*

**SIGNATURE :** **DATE:**

## MEDICAL HISTORY

**Present Physician :** **Phone # :**

**Last Visit :** **Reason for visit? :**

**Current Medications :** *(Please specify if none)*

| | | |
|---|---|---|
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |

**Please List Any Allergies :** **Medications:**
*(Please specify if none)*

**Other:**

**Do you have any history of asthma, hay fever or skin rashes?** **Yes / No**
**Have you ever had a reaction to a drug, medication or other?** **Yes / No**
*Codeine, aspirin, antibiotics, latex, dental anaesthetic(freezing), other :*
*Please list :* _____
**Have you ever had heart problems?** **Yes / No**
*Murmur, prosthetic cardiac valve, previous endocarditis,*
*congenital heart disease, cardiac transplantation, angina, stroke, other :*
*Please list :* _____
**Do you smoke ?** *Packs/day* **Yes / No**
**Do you have any blood disorders, or problems with bleeding?** **Yes / No**
**Do you snore?** **Yes / No**
**Do you often feel tired or sleepy during the day?**

**Please CIRCLE if you have any of the following :**

| | | | |
|---|---|---|---|
| **Epilepsy** | **Lung disease** | **Angina** | **Venereal Disease** |
| **Nervous Disorder** | **Tuberculosis (TB)** | **Artificial Joint/Heart Valve** | **AIDS / HIV** |
| **Headaches/Migraines** | **Anemia** | **Heart Surgery** | **Blood Transfusion** |
| **Fainting/Dizziness** | **Kidney Problems** | **Pace Maker** | **Hepatitis A/B/C** |
| **Thyroid Disease** | **Jaundice** | **High/Low Blood Pressure** | **Drug Addiction** |
| **Sinus Problems** | **Ulcers** | **Chemotherapy** | **Rheumatic Fever** |
| **Glaucoma** | **Arthritis** | **Steroids** | **Diabetes** |
| **Prosthetic implants** | **Joint replacements** | **Radiation Therapy** | **Clostridium Difficile** |
| **Creutzfeldt-Jakob Disease** | | **Prolonged Cough** | **Frequent Diarrhea** |
| **Vancomycin-Resistant Enterococcus (VRE)** | | **Methicillin-Resistant Staphylococcus Aureus (MRSA)** | |
| **Sleep Apnea** | | | |

**Do you have any conditions not listed :**

**For Women Only : Are you pregnant?** *Due Date:*

**UPDATES :** *For office use*

1. Date:
2. Date:
3. Date:

# DENTAL HISTORY

**Patient Name :**

**Last Dentist :** **Phone # :**

**Reason for last visit :** **Last X-Rays :**

**Dental concerns at this time:**

**What have you previous dental experiences been like?**

**What is your goal for future dental treatments? Are you satisfied with the appearance of your teeth?**

**Have you ever noticed any signs of periodontal disease?** **Yes / No**
*(Bleeding gums, recession, loose teeth or moving teeth)*
**Do you have sensitive teeth?** **Yes / No**

**Please CIRCLE if you have any of the following :**

| | | | |
|---|---|---|---|
| Clenching/Grinding | Sore Teeth/Jaw Upon Waking | Tired Jaw Muscles | |
| Tension/Migraine headaches | Sore Teeth when Biting | Stiff Neck | Clicking/ |
| Popping/Grinding in Joint | Difficulty Opening | Change in Bite | |
| Pain on Yawning/Chewing | TMJ/Splint Therapy | Stress | |

**Whom do we thank for referring you?**

This is to certify that I, the undersigned, consent to dental procedures agreed to be necessary or advisable for myself or my child, including the use of local anaesthetic, or other drugs as indicated and will assume responsibility for fees associated with those procedures. As well, I allow Sunshine Dental Centre to share my personal information with other Health Care Professionals and Benefit Companies as necessary, in order to assist in providing the best care for me. For the safety purposes of clients and staff, some procedures may require full surgical gowning. I give consent for those involved in the dental procedure to put on any surgical/sterile attire if necessary.

**NAME :** Please print:

**SIGNATURE :** **DATE:**