Adult information Sheet

☐ Picture
☐ Referral
Acknowledged

Date ____________________

Name ____________________ Address ____________________

Prefers __________ Pronounced __________ Town ____________________

Prov. __________ Postal Code __________ Phone ____________________

Date of Birth ____________________

Employer ____________________ PHONE ____________________ ext. __________

Occupation ____________________ Alternative Phone ____________________

Emergency Contact ____________________ Phone ____________________

Account Responsibility (if NOT SELF) __________ Relationship: ☐ Spouse ☐ Parent ☐ Other

Insurance Information:

Dental Insurance Carrier ____________________ Other (Co-Insurance) ____________________

Other Employer ____________________

Who can we thank for referring you to our office? ____________________

What prompted your decision to come here today? ____________________

____

Tell me about the experiences you have had in other dental offices:

How often per year ____________________ Last hygiene ____________________

Bad experience ____________________ X-rays ____________________

What do we need to know about you to ensure that your visits here are positive experiences? ____________________

____

To help us understand your past dentistry, have you experienced:

☐ Orthodontics ☐ Wearing retainer ☐ Periodontal Treatments ☐ Extractions

☐ Prosthetics ☐ Fixed ☐ Dentures __________ Age __________ Function __________

☐ Root Canal Treatment ____________________ ☐ Crowns ____________________

YES	NO	
☐	☐	Do you ever wake up with headaches?
☐	☐	Is it difficult to open or close?
☐	☐	Have you noticed if any teeth are becoming loose?
☐	☐	Does your jaw joint ever make noise?
☐	☐	Do you ever notice an unusually bad taste?

YES	NO	
☐	☐	Are you aware if you grind or clench?
☐	☐	Has any dentist adjusted your "bite"?
☐	☐	Is there an area where food always become caught? ____________________
☐	☐	Do your gums often bleed when you floss or brush?

There are some medications and health conditions which can complicate your dental treatment so we must ask some health questions:

YES	NO	
☐	☐	Have you seen a medical doctor in the past year? ____________________
☐	☐	Do you have an allergy to any medication or anaesthetic? ____________________
☐	☐	Are you currently taking any medication of any kind, including over the counter? Please list: ____________________
☐	☐	Are you tense during dental visits?
☐	☐	Are you interested in a method to calm your nerves?
☐	☐	Have you reason to believe that you are pregnant?
☐	☐	Is your snoring a problem for you or your spouse?

Continued on back side

Continued from front side

When was your last complete physical checkup? ______________________________

YES NO

☐ ☐ Do you have any prosthetic appliances/organs?

☐ ☐ Have you had a heart attack or surgery involving valves or pacemakers?

☐ ☐ Do you have angina?

☐ ☐ Have you had rheumatic fever or scarlet fever?

☐ ☐ Do you have a stomach ulcer?

☐ ☐ Do you have ☐ diabetes ☐ diet control ☐ medication control?

☐ ☐ Do you bruise unnecessarily, or bleed for prolonged periods?

☐ ☐ Hepatitis A ☐ Hepatitis B ☐ Latest Blood Test?

☐ ☐ Is your thyroid function normal? If no, is it ☐ overactive or ☐ underactive?

☐ ☐ Do you have chronic cold sores or canker sores?

YES NO

☐ ☐ Do you have heart murmur?

☐ ☐ Do you have ☐ high or ☐ low blood pressure?

☐ ☐ Have you had a stroke?

☐ ☐ Do you have epilepsy?

☐ ☐ Are you prone to fainting spells?

☐ ☐ Have you had TB or lung disease? ☐ Smoker

☐ ☐ Do you have ☐ asthma ☐ ventilator ☐ inhaler?

☐ ☐ HIV positive?

☐ ☐ Do you believe that you're in good health?

☐ ☐ Is there anything that the Doctor should know about your medical history that has not been mentioned? Such as: Arthritis, Hiatus, Hernia, Cancer, Psychological Problems (please circle) Other ______________________

Medical Doctor ______________________ Phone # ______________________

Office Policy: Your appointment time is reserved especially for you. If you are unable to keep your appointment we will require 2 business days notice, otherwise there is a fee charged for the **missed or cancelled appointment**. As a courtesy we try to confirm your appointment by phone, however, you are responsible for remembering your appointment. **Payment** is on a fee for service basis and is expected at the time of treatment. We accept MC, debit or Visa. Other financial arrangements should be discussed with the office manager prior to starting your treatment. Our goal, as always, is to help you attain your optimum dental health and appearance.

Thank You. Dr. Kim Parlett

DATE	DATE
CURRENT MEDICATION	CURRENT MEDICATION
NEW MEDICATION	NEW MEDICATION
NEW MEDICAL CONCERNS	NEW MEDICAL CONCERNS
NEW PATIENT CONCERNS	NEW PATIENT CONCERNS
STAFF INITIALS	STAFF INITIALS
DATE	DATE
CURRENT MEDICATION	CURRENT MEDICATION
NEW MEDICATION	NEW MEDICATION
NEW MEDICAL CONCERNS	NEW MEDICAL CONCERNS
NEW PATIENT CONCERNS	NEW PATIENT CONCERNS
STAFF INITIALS	STAFF INITIALS
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