CREEKSIDE DENTAL CARE

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality

About You *(please print clearly)*

Name _____
Surname Given Name Middle Initials Preferred

Address _____
Street

_____
City Prov Postal Code

Date of Birth ____/____/____ **Gender** M / F
DD MM YYYY **PHN:** _____

Telephone _____
Home Work Mobile

Can be best contacted at: □Home □Work □mobile **Best time to call:** _____

Email Address: _____

Emergency Contact _____ _____
Name Phone

Your Physician _____ _____
Name Phone

Who may we thank for referring you? _____

Dental Insurance **Yes** **No**

DRIVERS LICENSE# _____

1st Insurance		***2nd Insurance***	
Insurance Co.		Insurance Co.	
Name of Insured		Name of Insured	
Date of Birth of Insured	_____/_____/_____ DD MM YYYY	Date of Birth of Insured	_____/_____/_____ DD MM YYYY
Group / Plan No.		Group / Plan No.	
Certificate / ID No.		Certificate / ID No.	
Name of Employer		Name of Employer	

Dental History

Do you feel that your Dental Health is: Poor Average Excellent

What dental condition concerns you at the present? _____

When was you last visit to a dentist? _____ When was your last cleaning? _____

Do you have sore, aching or sensitive teeth?	**Yes No**
Do you Gums ever Bleed?	**Yes No**
Do you have pain or discomfort elsewhere on your face or jaw (TMJ)?	**Yes No**
Do you have any loose teeth?	**Yes No**
Do you grind or clench your jaw or teeth during the day or night?	**Yes No**
Does food catch frequently between any of your teeth?	**Yes No**
Are you Happy with the way your Smile looks?	**Yes No**
Would you like whiter teeth?	**Yes No**
Is snoring a problem for you?	**Yes No**
Is there anything else about you the Doctor should know about?	**Yes No**

If yes please list: _____

Medical History (please print clearly and circle Yes or No)

Are you under the care of a physician: **Yes No**
if yes, please explain:

Have you had a major operation? **Yes No**
If yes, please describe

Do you have any health problems that need further clarification? **Yes No**
if yes, please explain:

Have you ever had any complications following dental treatment? **Yes No**
If yes, please describe:

Do you now or have you ever had any of the following? (check all that apply)

Anemia	**Yes No**	Hepatitis A/B/C	**Yes No**
Angina	**Yes No**	High or Low Blood Pressure	**Yes No**
Arthritis	**Yes No**	HIV/AIDS	**Yes No**
Artificial Bones/Joints	**Yes No**	Joint Replacement (hip, knee, etc.)	**Yes No**
Artificial Heart Valve	**Yes No**	Kidney Disease	**Yes No**
Asthma	**Yes No**	Liver Disease	**Yes No**
Blood Disorder	**Yes No**	Lung Disease/Tuberculosis	**Yes No**
Cancer	**Yes No**	Mental Disorder	**Yes No**
Congenital Heart Defect	**Yes No**	Mitral Valve Prolapse	**Yes No**
Diabetes	**Yes No**	Pacemaker	**Yes No**
Emphysema	**Yes No**	Radiation	**Yes No**
Epilepsy/Seizures	**Yes No**	Rheumatic Fever	**Yes No**
Frequent Headaches	**Yes No**	Sinus Problem	**Yes No**
Glaucoma	**Yes No**	STD	**Yes No**
Hay Fever	**Yes No**	Stomach/Intestinal Problems	**Yes No**
Head Injuries	**Yes No**	Stroke	**Yes No**
Heart Attack	**Yes No**	Thyroid Disease	**Yes No**
Heart Murmur	**Yes No**	Tumors	**Yes No**
Hemophilia	**Yes No**	Ulcers	**Yes No**

Please list any other serious medical conditions you have or had in the past:

Please list any current medication you are taking:

Do you require pre-medications prior to dental treatment? **Yes No**

Are you Allergic to any of the following?

Penicillin	**Yes No**	Tetracycline	**Yes No**
Sedatives	**Yes No**	Dental Anesthetic	**Yes No**
Erythromycin	**Yes No**	Codeine	**Yes No**
Sulfa Drugs	**Yes No**	Keflex	**Yes No**
Metals	**Yes No**	Aspirin	**Yes No**
Latex	**Yes No**	Local Anesthetic	**Yes No**

Other Allergies

For Women:	Are you taking Birth Control Pills?	**Yes No**
	Are you Pregnant?	**Yes No**
	Are you Nursing?	**Yes No**

Have you ever had any complications with local anesthetic (freezing)? **Yes No**

Have you ever had complications with nitrous oxide? **Yes No**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing false or inaccurate information can be dangerous to my (patient's) health. It is my responsibility to inform Creekside Dental Care of any changes with my (or patient's) medical status.

Signature of patient, parent or guardian ***Print Name*** ***Date***