ARCHER DENTAL

Advancing dental care in our changing world

Patient Information and Medical History Forms

Date _____

Name _____ Birthdate _____ Home Phone_____

Email_____ Cell Phone:_____

Address _____ City _____ P.Code _____

Check Appropriate Box:☐Single☐Married☐Divorced☐Widow☐Other Birthplace_____

Employer _____ Occupation _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in Case of Emergency _____ Relationship_____

Responsible Party Phone _____

Name of Person Responsible for this account _____

Relationship _____

Address _____

Home Phone _____ Email_____

Employer _____ Work Phone _____

Is this person Currently a Patient in our Office:☑Yes ☐No

Insurance Information

Name of Insured _____ Birth Date _____

Relationship to patient _____

Name of Employer _____ Work Phone_____

Address of Employer _____ City _____ Province _____ P Code_____

Insurance Company _____ Certificate # _____Group# _____

Do You Have Any Additional Insurance?☐Yes☐No If yes, complete the following:

Name of Insured _____ Birth Date _____

Relationship to Patient _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ Province _____ P Code_____

Insurance Company _____ Certificate# _____ Group# _____

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Patient Medical History

Physician _____ Phone Number _____ Date of Last exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Are you in general good health at this time?	☐	☐
3. Have you ever been hospitalized for any surgical operations or any illnesses?	☐	☐
4. Are you taking any medication (s) including non-prescription medicine?	☐	☐
5. Do you smoke or chew tobacco?	☐	☐
6. Are you allergic to the following		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Aspirin	☐	☐
Other	☐	☐
Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you taking birth control pills?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Murmur	☐	☐	Hepatitis/jaundice	☐	☐
Low Blood Pressure	☐	☐	Thyroid problem	☐	☐	Liver disease	☐	☐
Heart Attack	☐	☐	Heart disease	☐	☐	Sexually transmitted disease	☐	☐
Rheumatic Fever	☐	☐	Cardiac pacemaker	☐	☐	Stomach troubles/ulcer	☐	☐
Fainting/Seizures	☐	☐	Chest pains/Angina	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Hay fever/allergies	☐	☐
Epilepsy/convulsion	☐	☐	Emphysema	☐	☐	Tuberculosis	☐	☐
Leukemia	☐	☐	Respiratory Problem	☐	☐	Radiation therapy	☐	☐
Diabetes	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Kidney disease	☐	☐	Arthritis	☐	☐	Recent weight loss	☐	☐
AIDS or HIV infection	☐	☐	Joint Replacement or implant	☐	☐	Other _____	☐	☐

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐	4. Do you clench your teeth?	☐	☐
2. Do you feel pain in any of your teeth?	☐	☐	5. Have you ever had any orthodontic work?	☐	☐
3. Have you had any head, neck or jaw injuries?	☐	☐	6. Have you ever had any prolonged bleeding following extractions	☐	☐

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	Yes	No
7. Have you ever experienced any of the following in your jaw?		
a) Clicking	☐	☐
b) Pain (joint, ear, side of the face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐

	Yes	No
9. Have you ever had instructions on the correct method of brushing your teeth?	☐	☐
10. Have you ever had instructions on the care of your gums?	☐	☐
11. Are you unhappy with the appearance of your smile?	☐	☐
12. Are you satisfied with the colour of your teeth?	☐	☐
13. Do you feel that you may have bad breath?	☐	☐

14. Please tell us any concerns you have about your teeth: _____

_____

_____

15. Name of Previous Dentist _____ Date of Last Visit _____

Photography

I consent to photography, filming, and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Patient/Guardian Name (Please Print): _____

Patient/Guardian Signature: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners which may be submitted electronically. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor _____