New Patient Form

Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office.

Basic Infsormation

First Name | Last Name | Date of Birth

Phone | Email | Preferred Contact Method

Address

City | Province | Postal Code

Type of Appointment

○ New Patient ○ Emergency ○ Consultation ○ Other

Please Explain

Health History

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.

1-Are you being treated for any medical condition at present or within the past year?

○ Yes ○ No ○ Maybe/Not Sure

Please Explain

2- When was your last medical check up?

3- Have there been any changes in your general health in the past year? ○ Yes ○ No

4- List any prescription or non-prescription drugs you are taking or have recently taken including birth control pills.

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I N F O @ A R I . D E N T A L

5- Do you have any allergies?

Yes No Not Sure

6- Have you ever had a peculiar or adverse reaction to any medicines or injections?

Yes No Not Sure

7- Do you have, or have you ever had, any heart or blood pressure problems (heart or stroke)?

Yes No

8- Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) or have you ever had Rheumatic Fever?

Yes No

9- Do you have any prosthetic or artificial joints (e.g. hip, knee)?

Yes No

10- Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders?

Yes No

11- Have you ever been hospitalized for any illness or operations?

Yes No

12- Indicate which of the following you presently have, or ever had: (Please check all that apply)

- Asthma
- Bronchitis
- Emphysema
- Lung Disease
- Hepatitis B or C
- Jaundice
- Liver Disease
- Tuberculosis
- Diabetes
- Kidney Disease
- Thyroid Disease
- Glandular Disorders
- Organ Transplant / Medical Implant
- Stomach or Intestinal Problems
- Ulcers
- Epilepsy or Seizures
- HIV+
- Nervous Disorders

13- Do you currently have, or ever had in the past, any disease, condition or problem not listed above?

Yes No

14- Are there any diseases or medical problems that run in your family?

Yes No

15- Are you a smoker?

Yes No

WOMEN ONLY: Are you pregnant or breast feeding?

Yes No Not Sure

I certify that I have provided an accurate and complete personal and medical/dental history to the best of my knowledge. All information is confidential and is accessed only via a secure, encryptped interface. Should there be any change in my personal or health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services. I understand that 48 hours notice is required for changing or cancellation of my appointments, otherwise there is $70 charge per hour that may be applied.

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Signature(Patient/Guardian)

Date