Welcome to our office. Please fill out form completely. This information is confidential.

Personal Information

Name: ______________________________________ Date of Birth: ________________________

Address: ____ Postal Code: _____________

Hm #: ______________________ Cell #: _______________________ Bus #: ___________________________

Occupation: _____________________________ Employer: ____

AHC #: _________________________ Email: ____

Spouses Name: ___________________________ Parent/Guardian (if under 18): ________________________

Whom may we thank for referring you to us? ____

Emergency Contact (name and #): ____

Medical History

1. Personal Physician: ____
2. Pharmacy: ____
3. Have you had a medical exam in the last year? ____
4. Have you ever had/have a serious illness or are you under the care of a physician now? _________________
5. Do you use ANY prescription medicine regularly? Please list _____________________________________
   ____
6. Do you use ANY OTC supplements/medications regularly? Please list ______________________________
   ____
7. Do you have ANY allergies? Please list ____
8. Have you experienced any unusual reaction to any of the following drugs? (circle all which apply)

Aspirin   Penicillin   Iodine   Sulfa   Barbiturates   Local Anaesthetic   other medicine

9. Do you bruise easily or bleed abnormally? ____
10. Do you have a heart murmur or artificial heart valve or joint replacement? __________________________
11. Have you ever been hospitalized or had surgery for any other reason? ______________________________
12. Is there any history of family disease? Please list ____
13. Do you smoke, use tobacco or cannabis products of any kind? Please list ____________________________
14. Do you have OR have you had? (circle all which apply)

Heart trouble   High Blood Pressure   Kidney trouble   Yellow jaundice   Epilepsy   Thyroid trouble

Blood disorders   Diabetes   Anaemia   Venereal diseases (syphilis, gonorrhoea)

Tuberculosis   Mental health (type) _____________   Hepatitis (type) _________   AIDS

Any others (Specify) ____

Consent to Treatment and Permit for Operations

Please ask us about our privacy policy for more information. This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for the fees associated with those procedures.

SIGNATURE: ____ DATE: ____________________