Welcome to OraCare Dental

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

Patient Information

A parent or guardian will be responsible for decisions on my treatment ☐Yes ☐ No

Name:_____
First Initial Last

Address:_____
Street Apt. City Prov. Postal Code

Date of Birth: ____ / ____ / ____ Home Tel: (____)_____ Work Tel:(____)_____
D M Y Cell #: _____

Emergency Contact: _____ Tel: (____)_____

Family Doctor: _____ Tel: (____)_____

Referred By: _____ Tel: (____)_____

Financial Information

Method of payment: Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐

Person responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: ____ / ____ / ____ Home Tel: (____)_____ Work Tel:(____)_____
D M Y

Driver's Lic: _____ OHIP#_____

Dental Ins Comp:_____ Tel:(____)_____

Employer/Policy Holder:_____ Ins.Yr.End:_____

Policy# _____ Certificate# _____ ID/SIN#_____

Max:Cov:_____% coverage for_____ Basic_____ Maj.Restorative_____ Orthodontic _____

Dental History

1.What is the reason for today's visit? ☐ Emergency ☐Examination ☐ Other _____
2.How frequently do you see a dentist? ☐3-6 months ☐ Annually ☐ Other _____
3.When was your last dental visit?_____ Last x-ray_____
4.How often do you brush per day? _____ Floss?_____ Use anti-bacterial rinse _____
5.Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat Other _____
6.Do your gums bleed when: ☐ Brushing ☐ Flossing ☐Never

	YES	NO
7.Do your gums feel swollen or tender?	☐	☐
8.Do you have bad breath or bad taste in your mouth?	☐	☐
9.Do your jaws crack, pop or grate when you open wide?	☐	☐
10.Do you grind or clench your teeth?	☐	☐
11.Do you have food catch between your teeth?	☐	☐

12.Have you ever had local anesthetic (freezing)? ☐ Yes ☐ No / Any Complications? Specify_____
13.Have you ever had any problems with previous dental treatments? Specify_____
14.Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps ☐ Full or Partial Dentures
☐ Orthodontic (braces) ☐ Periodontal (gums) ☐ Root Canal

15.Are you satisfied with your teeth? Specify?_____ ☐ ☐

Medical History (this information will remain confidential)

Date:_____

	YES	NO
1. Are you presently under the care of a physician? If so, explain_____	☐	☐
2. Have you ever been hospitalized? Explain_____	☐	☐
3. Are you taking any drugs or medication at this time?_____	☐	☐

A) Drug_____ Reason_____
B) Drug_____ Reason_____
C) Drug_____ Reason_____

4. Have you ever had any adverse effect to any of the following: **Antibiotic-Penicillin** ☐, **Sulfonamide** ☐, **Other** ☐;
Aspirin ☐; **Barbiturates (sleeping pills)** ☐; **Codeine** ☐; **Darvon** ☐; **Local Anaesthetic** ☐; None ☐.

5. Have you ever been warned against using any other medications? Which?_____	☐	☐
6. Have you ever taken prolonged medical or non-medical drugs? Which?_____	☐	☐
7. Do you suffer from any allergies (hay fever, latex etc.)? Which?_____	☐	☐
8. Do you bruise easily or have prolonged bleeding?.....	☐	☐
9. Do you smoke? How much per day?_____	☐	☐
10. Have you ever fainted, had shortness of breath or chest pains?.....	☐	☐

11. **Women** Are you pregnant? Yes ☐ No ☐ Using Birth Control? Yes ☐ No ☐ Reached Menopause Yes ☐ No ☐

12. Do you have or have you ever had any of the following? Please ✔ appropriate boxes. **NONE** ☐

☐A.I.D.S.	☐ Cortisone/Steroid	☐High/Low Blood pressure	☐Psychiatric Disorders
☐Anemia	☐ Diabetes	☐H.I.V. Positive	☐Radiation/Chemotherapy
☐Angina pectoris	☐ Drug/alcohol dependence	☐Hodgkin's disease	☐Rheumatic/Scarlet fever
☐Artificial Heart Valve	☐Emphysema	☐Hyper(Hypo)Glycemia	☐Sickle Cell disease
☐Arthritis/rheumatism	☐Epilepsy	☐Hypertension	☐Sinus trouble
☐Artificial joints(hips,knees)	☐Glandular disorders	☐Jaundice	☐Stomach/intestinal problems
☐Asthma	☐Glaucoma	☐Kidney disease	☐Stroke
☐Blood Disorders	☐Head/neck injures	☐Liver disease	☐Thyroid disease
☐Anorexia nervosa	☐Heart disease/attack	☐Leukemia	☐Tuberculosis
☐Bronchitis	☐Heart Murmur	☐Lung disease	☐Ulcers
☐Bulimia	☐Heart pacemaker/surgery	☐Malignant hypothermia	☐Venereal disease
☐Cancer	☐ Heart rhythm disorder	☐Mental/nervous disorder	☐Other_____
☐Circulation problems	☐Hepatitis A/B/C	☐Mitral valve proplase	☐Other_____
☐Congenital heart lesions	☐Herpes	☐Organ transplant	☐Other_____

13. **Children** have you recently had any of the following (approximate date)?

☐Chicken pox _____ ☐Measles _____ ☐Mumps_____
☐Strep Throat _____ ☐Tonsillitis _____ ☐None

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both my dependents and myself. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____
Signature ☐ Patient ☐Parent/Guardian Print Name Date

Thank you