GENERAL INFORMATION

The information contained herein is considered confidential and is for our records only.

Name:_____ Date of Birth:_____

Address:_____

City:_____ Province:_____ Postal Code:_____

Telephone numbers: Home_____ Work_____ Other_____

E-Mail Address_____

Referring Dentist:_____ Telephone Number:_____

How long have you been a patient of the above dentist?_____

Name of your physician:_____ Telephone Number:_____

Date of last physical examination:_____

Findings:_____

Do you have dental Insurance?_____Group:_____ID:_____

DENTAL HISTORY

1. Present dental complaint or concern?_____

_____

2. Are you having any dental discomfort or pain?_____

3. Do your gums bleed? _____ When _____

4. Have you ever had; A gum abscess?_____ Swollen Gums?_____ Loose teeth?_____

5. Do you clench or grind your teeth?_____

6. When were your teeth last “Cleaned” in a dental office?_____

7. How long before that?_____

8. How often do you brush your teeth?_____

9. What sort of brush do you use? Soft_____ Medium_____ Hard_____

10. Do you regularly use anything else to clean your teeth?_____

11. Are your teeth Sensitive?_____

12. Have you had previous orthodontic treatment?_____

When?_____ Where?_____

13. Have you had previous periodontal?_____

When?_____ Where?_____