OAKVILLE LANE DENTAL

Title: _____ Name_____ Date of Birth_____

Mailing Address_____ City_____ Prov. _____ Postal Code_____

Phone#_____ Work# _____ Cell# _____ Email_____

Family Doctor_____ Occupation_____

Referred By_____

Dental History

When was your last visit to the dentist? _____
What is reason for your dental visit today? _____

Please answer the following in regards to your dental health/habits:
Do you floss? YES/NO, How often? _____
Do you drink Coffee/Tea/Pop/ Fruit Juice? How Often? _____
Do you smoke Cigarettes/E-Cigarettes/Cannabis? How Often? How Long?_____
Do you get Canker Sores/Cold Sores? How Often? _____
Do you have any oral habits? Nail biting/Thumb Sucking/ Pen chewing?_____
Do you currently have any dental implants, dentures, or partials? _____
Do you clench/grind your teeth? Do you have any pain in your jaw or experience headaches?
Explain: _____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

Medical History

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's Name & Phone Number: _____

WOMEN ONLY: Are you pregnant? ○ Yes ○ No If Yes, when is the due date?_____

Please answer the following questions and explain (if necessary):
Do you have any allergies? ie Penicillin/Latex?_____
Have you had any reactions to any drugs or medications? To what? _____
Do you require any pre-medication prior to dental treatment? _____
Have you had any major operations or been hospitalized in the last 6 months? _____
Have you taken cortisone or steroids in the last 6 months? _____
Do you have any mobility issues? _____

More information to be collected on back

Please indicate if you have or have experienced any of the following

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial joint(s) and/or heart valves
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Abnormal Bleeding/ Bruising
- ☐ Blood Disease
- ☐ Cancer
- ☐ Dementia
- ☐ Diabetes Type I/II
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Gastro-intestinal Issues
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV+ (AIDS)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Disorder
- ☐ Multiple Sclerosis
- ☐ Nervous System Disorder
- ☐ Pacemaker
- ☐ Radiation Therapy/Chemotherapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rash/Hives
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Temporomandibular Joint Disorder
- ☐ Tumors/ Growths
- ☐ Ulcers
- ☐ Other: _____

Please list any medications you are currently taking: _____

_____

Do you have any other conditions, diseases, etc., not listed above that we should be aware of? _____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dentalpractice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

_____ _____

Signature **Date**

Relationship to Patient: _____