Welcome to Danube Dental Clinic

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

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth_____/____/_____ Home Tel.(___) _____ Work Tel.(___) _____

Email: _____ Cell #_____

Emergency contact: _____ Tel. (___) _____

Family Doctor: _____Tel.(____)_____

Referring Person: _____

Financial Information:

Method of payment: Cash _____ Cheque _____ Credit Card ____ Insurance _____ Other _____

Person Responsible for financial matters: Self_____ Spouse_____ Parent/Guardian _____ Other_____

Primary Insurance:

Ins.Company _____

Employer/Policy Holder _____

Policy/Group # _____ Certificate #_____

Secondary Insurance

Ins. Company _____

Employer/Policy Holder _____

Policy# _____ Certificate# _____

General Consent Statement

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general or local anesthetic, as required, to achieve the diagnostic procedures and treatment, including general or local anesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive. I know that your office has a privacy code, and I can ask to see the code at any time. I agree that your office can collect, use and disclose personal information about me as set out in your office privacy policy.

_____ _____ _____

Signature: Self__Parent/Guardian Print Name Date

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)_____ b)_____ Reason_____	____	____
	c)_____ d)_____ Reason_____	____	____
	e)_____ f)_____ Reason_____	____	____
4.	Have you ever had any adverse effect to any of the following: Antibiotics – Penicillin __Sulphonamide ___Other__ Aspirin____, Barbiturates (sleeping pills) ___, Codeine____, Darvaon____, Local Anaesthetic___, None_____		
5.	Have you ever been warned against using any other medications? _____		
6.	Have you ever taken prolonged medical or non-medical drugs? _____	____	____
7.	Do you suffer from any allergies (hay fever, latex etc.)? _____	____	____
8.	Do you have or have you ever had: a) Any heart or blood pressure problems? _____	____	____
	b) A heart murmur or mitral valve problem? _____	____	____
	c) Hepatitis, Jaundice or Liver Disease? _____	____	____
9.	Do you have any condition that could affect your immune system, e.g. Leukemia, AIDS, HIV Positive? _____	____	____
10.	Do you bruise easily or have prolonged bleeding? _____	____	____
11.	Do you smoke? How much per day? _____	____	____
12.	Have you ever fainted, had shortness of breath or chest pain? _____	____	____
13.	Are you pregnant? Yes No Using birth control? Yes No Reached menopause Yes No	____	____

14. Do you have or have you ever had any of the following?

None

- ☐ A.I.D.S.
- ☐ Anaemia
- ☐ Angina pectoris
- ☐ Anorexia nervosa
- ☐ Artificial heart Valve
- ☐ Arthritis/rheumatism
- ☐ Artificial joints (hip/knee)
- ☐ Asthma
- ☐ Blood disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Circulation problems
- ☐ Congenital heart lesions
- ☐ Cortisone/steroid
- ☐ Diabetes
- ☐ Drug/Alcohol Dependence
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glandular disorders
- ☐ Glaucoma
- ☐ Head/neck injuries
- ☐ Heart disease/attack
- ☐ Heart murmur
- ☐ Heart pacemaker/surgery
- ☐ Heart rhythm disorder
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ High/low Blood pressure
- ☐ H.I.V. Positive
- ☐ Hodgkin's disease
- ☐ Hyper (Hypo) Glycemia
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Leukemia
- ☐ Lung disease
- ☐ Malignant hypothermia
- ☐ Mental/nervous disorder
- ☐ Mitral valve prolapse
- ☐ Organ transplant/implant
- ☐ Psychiatric disorders
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic/Scarlet fever
- ☐ Sickle cell disease
- ☐ Sinus trouble
- ☐ Stomach/intestinal problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other
- ☐ Other
- ☐ Other

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-rays? _____
4. How often do you brush per day? _____Floss _____Use anti-bacterial rinse? _____
5. Are your teeth sensitive to: Sweet Heat Cold
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 a bad taste in your mouth? _____	____	____
9.	Do your jaws crack or pop when you open widely? _____	____	____
10.	Do you grind or clench your teeth? _____	____	____
11.	Do you have food traps between your teeth? _____	____	____
12.	Have you ever had any complication with local anaesthetic (freezing)? _____	____	____
13.	Have you ever had any problems with previous dental treatment? Specify_____	____	____
14.	Have you ever had any of the following dental treatment: Bridgework Crowns or Caps Full or Partial dentures? Orthodontic (braces) Periodontal (gums) Root canal	____	____
15.	Are you satisfied with your teeth? Specify_____	____	____

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Thank you