



Patient Information (all information is strictly confidential and will remain with this office) Patient #: _____

Name: _____
Last First Prefer to be called

Address: _____
Street City Prov Postal Code

Telephone: _____
Home Work Cell

Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Month / day / year

Employed by: _____ Occupation: _____

How did you hear about our office? Friend/Family _____ If so: _____

☐ Facebook ☐ Google ☐ Yellow Pages ☐ Website ☐ Email Blast ☐ Contest ☐ Other: _____

Medical Information

Medical doctor: _____ Telephone: _____

Date of last physical exam: _____ Do you consider yourself to be in good health: _____

Are you presently under the care of a medical doctor: ☐ Yes ☐ No If yes please specify _____

Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins: ☐ Yes ☐ No

Do you have any allergies or have you had any reaction to (medications, anesthetics, metals, latex, antibiotics, pain killers, dairy, etc.): _____

Do you have to take antibiotics prior to dental work? ☐ Yes ☐ No If yes, why? _____

Have you had heart surgery? ☐ Yes ☐ No If yes, please specify: _____

Do you have any artificial prosthesis (Joints, heart valve, etc)? ☐ Yes ☐ No If yes please specify: _____

Do you have abnormal bleeding? ☐ Yes ☐ No Do you become breathless easily? ☐ Yes ☐ No

Do you have or have had any of the following:

High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis type	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hiv/aids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digestive disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Or Neck injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiation therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antidepressants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol/drug Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No

Others: _____

Do you smoke? ☐ Yes ☐ No If so how much? _____ Do you take recreational drugs? ☐ Yes ☐ No
Women: Are you taking Birth Control Pills? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Dental History

Are you having any discomfort at this time? If yes please specify: _____

Have you been under the regular care of a dentist? _____ How long since your last dental visit: _____

What was done at that time? _____

Do your gums feel tender or swollen? ☐ Yes ☐ No Is there often bleeding when you floss? ☐ Yes ☐ No

Have you ever been given local anesthetic (freezing)? ☐ Yes ☐ No

Have you ever had general anesthetic? ☐ Yes ☐ No

Are you aware of any lump or swelling in your mouth? ☐ Yes ☐ No

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

Are you tense during your dental visits? ☐ Yes ☐ No

Describe what you would like done with your teeth: _____

Do you currently experience any of the following?

Loose teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	:	Ear ache	<input type="checkbox"/> Yes <input type="checkbox"/> No	:	Spaced or crooked teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	:	Gagging	<input type="checkbox"/> Yes <input type="checkbox"/> No	:	Unexplained nose bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No
Missing Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	:	Sore Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	:	Popping or clicking of the jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	:	Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	:	Unsatisfactory Dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No

Account Information

Person financially responsible for the account: _____

Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep your appointment we require 48 hours notice, otherwise, it may be necessary to charge for the time lost.

Communication Policy

I also authorize Capital Dental Clinic to communicate with me electronically for the purpose of sending me educational and promotional information, etc. ☐ Yes I consent

I acknowledge that I can revoke consent at any time by communicating directly with Capital Dental Clinic.

Our Consent

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, and I will assume responsibility for fees associated with those procedures.

Date: _____ Patient/ Guardian signature: _____

Please arrive 10 minutes before your appointment.