CARRIAGE
PLACE DENTAL

Today's date: _____

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

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? ___ Facebook ___ Google ___ Yellow Pages ___ Friend/Family ___ Blog ___ Existing Patients

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:

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? If yes, why? _____
Have you had heart surgery? If yes, please specify: _____
Do you have any artificial prosthesis (Joints, heart valve, etc)? 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	Yes	No	Glaucoma	Yes	No	Heart murmur	Yes	No
Digestive disorders	Yes	No	Diabetes	Yes	No	Emphysema	Yes	No
Sinus problems	Yes	No	Cancer	Yes	No	Psychiatric care ____	Yes ____	No
Low blood pressure	Yes	No	Heart trouble	Yes	No	**Hiv/aids**	Yes	No
Head or Neck injuries	Yes	No	Kidney trouble	Yes	No	Osteoporosis	Yes	No
Venereal Disease	Yes	No	Ulcer	Yes	No	Anemia	Yes	No
Nervous problems	Yes	No	Hepatitis type	Yes	No	Thyroid disease ____	Yes ____	No
Radiation therapy	Yes	No	Chest pain	Yes	No	Arthritis	Yes	No
Alcohol/drug dependency____	Yes ____	No	Blood disorders	Yes	No	Epilepsy	Yes	No
Tuberculosis	Yes	No	Liver disease	Yes	No	Chemotherapy	Yes	No
Headaches	Yes	No	Asthma	Yes	No	Antidepressants ____	Yes ____	No
Herpes	Yes	No	Rheumatic Fever____	Yes	No	Stroke	Yes	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

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

Signed: _____

Account Information

Person financially responsible for the account: _____

Dental History

Are you having any discomfort at this time? If yes please specify: _____
_____
Have you been under the regular care of a dentist?___Yes___No 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 anxious to keep your natural teeth? ___ Yes ___ No
Are you tense during your dental visits? ___ Yes ___ No
Are you interested in a method to calm your nerves? ___ Yes ___ No
Describe what you would like done with your teeth: _____
_____

Do you currently experience any of the following?

Loose teeth ____ Yes _____ No Ear ache ____Yes _____ No Spaced or crooked teeth ____Yes ____ No
Bad Breath ____ Yes _____ No Gagging _____Yes _____No Unexplained nose bleeds ____Yes ____ No
Missing Teeth ____ Yes _____ No Sore Gums ____Yes ____No Popping or clicking of the jaw ____Yes ____ No
Bleeding gums ____Yes _____ No Headache ____Yes ____ No Unsatisfactory Dentures _____ Yes ____ No

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.

I understand that I am ultimately responsible for the total fees associated with the treatment performed.

Date: _____ Patient/ Guardian signature: _____