98 Boul Laflèche
Casselman ON K0A1M0
613 764 6600 (T)
613 764 5500 (F)
info@dentisterieatcasselman.ca

PATIENT INFORMATION-PLEASE PRINT CLEARLY

Please take a moment to enter your information in order to help us ensure the quality of your care

Patient Name:____

Gender: Male:____Female:____

Family Status: Married:___Single:___Child:___Other:___

Date of Birth:____________________

Email Address:____

Phone:____________________(h) _______________________(w)
________________________(c)

Address:____

____

How did you hear about us?

Dental Office:___Drive by:___ Staff:___ Family or Friends:___ Internet:___

Newspaper:___ Other:____

Name of person or other source of
referral:____

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Medical and Dental History:

Please take a moment to let us know about your medical/dental history so we may serve you more efficiently and in a way that looks out for your overall health and well being.

Would you consider yourself to be in good health:

Yes_____ No_____

Within the last year, have there been any changes in your general health?

Yes_____ No_____

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

Your primary care physician's name, address & phone number:____

Please mark any of the following to indicate YES in response to the question:
___Have you ever had complications following dental treatment?

___Are you currently under the care of a physician due to a specific condition?

___Have you been hospitalized within the last 5 years due to surgery or illness?

___Are you currently taking any prescription or non-prescription medications?

___Do you use tobacco? (smoking or chewing) Frequency?______

___Do you require the use of corrective lenses? (contacts or glasses)

___Do you have any other conditions, diseases, etc, not listed above that we should be made aware of?

If any of the previous questions are marked, please explain:

For women only:
Are you pregnant?Yes___ No___ Due date:_________________

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Please indicate if any of the following apply to you:

___Pre-medication	___See notes	___Allergy-See notes
___Allergy-Aspirin	___Allergy-Codeine	___Allergy-Iodine
___Allergy-Latex	___Allergy-Penicillin	___Allergy-Sulfa
___Allergy-Erythromicin	___Allergy-Local Anes	___Anemia
___Arthritis	___Artificial Joints	___Asthma
___Blood Disease	___Cancer	___Contraceptive Use
___Dental Phobia	___Diabetes	___Dizziness/Fainting
___Emphysema	___Epilepsy	___Excessive Bleeding
___Excessive Bruising	___Gastro-Intestinal	___Glaucoma
___Hard to Freeze	___Hay Fever	___HBP
___Head Injury	___Hearing Disabled	___Heart Disease
___Heart Murmur	___Hepatits A-B-C -___Specify	___HIV+(AIDS)
___Hives	___Kidney Disease	___LBP
___Liver Disease	___Mental Disorders	___Multiple Sclerosis
___Nervous Disorders	___Pacemaker	___Radiation Treatment
___Respiratory Problems	___Rheumatic Fever	___Rheumatism
___Rheumatoid Arthritis	___Sinus Problems	___Skin Rash
___Sleep Apnea	___STD	___Stomach Problems
___Stroke	___Thyroid Disease	___TMD
___Tuberculosis	___Tumors	___Ulcers

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If there is one thing you would like to change about your smile, what would it be?

What is the main reason for your visit with us today?______________________________

When was your last dental visit?____

What was done on your last dental visit?____

Previous Dentist name, address & phone number:____
____

How frequently do you brush your teeth?

___3 + times/day ___Twice/day ___Once/day ___Weekly ___Seldom

How frequently do you floss your teeth?

___1+/day ___2-6 times/weekly ___1-6 times/month ___Seldom ___Never

Please mark any of the following to indicate YES in response to the question:

___Do your gums bleed when you brush?

___Do your teeth experience sensitivity to cold or hot temperatures?

___Are any of your teeth currently causing you pain?

___Do you grind your teeth? (consciously or during sleep)

___Are any of your teeth loose or are you concerned about teeth loosening?

___Do you currently have any dental implants, dentures or partials?

If any of the previous questions are marked, please explain:

Patient Signature___________________________________Date:____________________

Witness Signature__________________________________Date:____________________