ACORADENTAL

Patient Information

Name: _____ Date: _____
First Initial Last

Address: _____ City: _____ Province: ___

Postal Code: _____ Phone # _____ Work / Cell #_____

Date of Birth _____/ ____/ _____ Email: _____
D M Y

Emergency Contact: _____ Phone/Cell _____

DENTAL HISTORY

What is the reason of your visit? ❑Emergency ❑Examination ❑Other _____

How frequent do you see a dentist? ❑3-6 months ❑Annually ❑Other _____

Are your teeth sensitive to ❑Cold ❑Heat ❑Sweets ❑Other _____

Do your gums bleed when ❑Brushing ❑Flossing ❑Never

When was your last visit? _____ Last X-Ray? _____

Is there anything bothering you at this time? What? _____ Yes ❑ No ❑

Have you ever had complicated dental treatment? Yes ❑ No ❑

Have you ever had complications as a result of dental treatment? Yes ❑ No ❑

Have you ever had a problem with freezing? Yes ❑ No ❑

Do you get nervous or anxious before coming to the dentist? Yes ❑ No ❑

Is there any treatment you have wanted but put off? Yes ❑ No ❑

Have you noticed any: ❑Swelling ❑Bleeding Gums ❑Sore Gums ❑Receding Gums

Do you have teeth that:

❑Bother you when biting down ❑Temperature Sensitive

❑Ache ❑Feel loose

Do you experience any difficulty chewing? Yes ❑ No ❑

Does food wedge between your teeth? Yes ❑ No ❑

Any previous injury to your jaw / face? What? _____ Yes ❑ No ❑

Do you notice clicking or popping when you chew or yawn? Yes ❑ No ❑

Do you clench or grind your teeth? Yes ❑ No ❑

Do you suffer from frequent migraine headaches? Yes ❑ No ❑

Have you ever undergone orthodontic treatment? Yes ❑ No ❑

HEALTH AND MEDICAL HISTORY UPDATE

To help us ensure your well being while undergoing treatment in our practice, please answer the following questions in the most detail possible. The information you provide is confidential and for our records only. **It is important for your health and safety that you notify us of any changes to your medical history at each visit.**

Are you presently under a physician's care now? Why? _____ Yes ❑ No ❑

Have you been hospitalized recently? Why? _____ Yes ❑ No ❑

Do you have any changes in health history in the past 24 hours? _____ Yes ❑ No ❑

Have you been in contact with any person known to have communicable infectious diseases in the past 24 hours? Yes ❑ No ❑

What medications are you taking or have you taken in the past year: (check all that apply)

❑Antibiotics / Sulfa Drugs ❑Anticoagulants ❑Tranquilizers ❑Aspirin/Tylenol/Ibuprofen

❑Insulin, Orinase, etc. ❑Nitro-glycerine ❑Blood Pressure ❑Heart Medication

❑Other: _____

Are there any other conditions not listed that we should know about? What? _____ Yes ❑ No ❑

Are you taking any drugs or medication at this time? What? _____ Yes ❑ No ❑

Have you ever been warned against using any medications? Which? _____ Yes ❑ No ❑

Do you bruise easily or have prolonged bleeding? _____ Yes ❑ No ❑

Do you smoke? How much per day? _____ Yes ❑ No ❑

Have you ever fainted, had shortness of breath or chest pain? _____ Yes ❑ No ❑

WOMEN only: Is there any possibility of pregnancy at this time? How far along? _____ Yes ❑ No ❑

Are you allergic to or ever had an adverse reaction to: (check all that apply)

❑Local Anesthetic ❑Codeine ❑Sedatives ❑Epinephrine ❑Latex

❑Penicillin / Sulfa Drugs ❑ Other: _____

Do you have or have you ever had any of the following? (please check all that apply)

❑AIDS	❑Circulation problems	❑Hemophilia	❑Malignant Hypothermia
❑Abnormal bleeding	❑Congenital Heart lesions	❑Hepatitis A / B / C	❑Mitral Valve prolapsed
❑Alcohol / Drug abuse	❑Colitis	❑Herpes	❑Radiation/Chemotherapy
❑Anemia	❑Diabetes	❑High/Low Blood Pressure	❑Rheumatic/Scarlet fever
❑Angina Pectoris	❑Emphysema	❑H.I.V.	❑Seizures
❑Artificial Heart Valve	❑Epilepsy	❑Hodgkin disease	❑Sickle cell disease
❑Arthritis/ Rheumatism	❑Fainting Spells	❑Hyper (Hypo) Glycemia	❑Sinus Trouble
❑Artificial Joints / Valves	❑Glandular Disorders	❑Hypertension	❑Stroke
❑Asthma	❑Glaucoma	❑Jaundice	❑Thyroid problems
❑Blood disorders	❑Head/Neck injuries	❑Kidney Disease	❑Tuberculosis T/B
❑Bronchitis	❑Heart disease/Attack	❑Liver Disease	❑Ulcers
❑Bulimia	❑Heart Murmur	❑Leukemia	❑Venereal disease
❑Cancer	❑Heart Surgery	❑Lung Disease	

❑Other: _____

Have you ever had any other serious illness not checked above? Discuss _____ Yes ❑ No ❑

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at the next appointment without fail.

_____ _____ _____

Signature of ❑Patient ❑ Parent or Guardian Print Name Date