ALIGNDENTAL

PATIENT INFORMATION AND HEALTH HISTORY

Last Name: _____ First Name (legal): _____ Preferred name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Ph: _____ Mobile: _____ Work: _____

Date of Birth: Day: _____ Month: _____ Year: _____ Email Address: _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Minor ☐ Other Gender: ☐ Male ☐ Female

Financially responsible for this account? ☐ Self ☐ Guardian ☐ Other: _____

How did you hear about our office? : _____

Reason for today's visit: _____

DENTAL INSURANCE

Primary Coverage

Member's Name: _____

Member's DOB: _____

Insurance Co: _____

Group No: _____

ID No: _____

Employer/School: _____

Relation: _____

Primary Coverage

Member's Name: _____

Member's DOB: _____

Insurance Co: _____

Group No: _____

ID No: _____

Employer/School: _____

Relation: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone No.: _____

Physician's Name: _____ Physician's City: _____

Approximate date of last physical examination/visit to a MD: _____

Have you been hospitalized in the past 3 years? ☐ Y ☐ N _____

Have you ever had a major operation? ☐ Y ☐ N If yes, what kind/when?: _____

_____

_____

Please list any medications you are currently taking: _____

_____

_____

Please list any additional medications taken in the past 3 years: _____

_____

Do you have any allergies? (Ex. Penicillin, Ibuprofen, Codeine, Aspirin, Latex). If yes, please specify:

_____

_____

Do you have any sensitivity/reactions towards any medications? _____

_____

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The following information is vital in case of an emergency situation (and for emergency prevention). This information is strictly confidential.

Please check "Yes" or "No" to the following conditions or treatments which you **have had** or currently **have**:

AIDS/HIV	Y N	Drug/Alcohol Addiction	Y N	Liver Disease	Y N
Alzheimer's Disease	Y N	Emphysema	Y N	Lung Disease	Y N
Anaphylaxis/Allergy	Y N	Endocrine Disease	Y N	Muscle Damage/Trauma	Y N
Anemia	Y N	Epilepsy/Seizures	Y N	Organ/Medical Transplant	Y N
Arthritis/Joint Pain	Y N	Fainting/Dizziness	Y N	Osteoporosis	Y N
Artificial Heart Valve	Y N	Gastrointestinal	Y N	Psychiatric Treatment	Y N
Artificial Joints	Y N	Glaucoma	Y N	Radiation Therapy	Y N
Asthma	Y N	Hay Fever	Y N	Respiratory	Y N
Autoimmune Disease	Y N	Head/Neck Injury	Y N	Rheumatic Fever	Y N
Blood Disease	Y N	Heart Attack/Failure	Y N	Scarlet Fever	Y N
Blood Transfusion	Y N	Heart Murmur	Y N	Seizures	Y N
Bruise Easily	Y N	Heart Pacemaker	Y N	Sickle Cell Disease	Y N
Cancer/Tumor	Y N	Heart Surgery	Y N	Sinus Trouble	Y N
Chemotherapy	Y N	Hemophilia	Y N	Sleep Apnea	Y N
Chest Pain/Discomfort	Y N	Hepatitis A, B, C	Y N	Stroke	Y N
Circulation Problems	Y N	High/Low Blood Pressure	Y N	Thyroid Disease	Y N
Diabetes	Y N	Kidney Disease	Y N	Tuberculosis	Y N

Other conditions not listed above/more details for conditions listed:

Do your gums bleed when you brush/floss?	Y N	Are you pregnant?	Y N
Do you experience clicking or pain in your jaws?	Y N	Do you feel dizzy when reclined?	Y N
Any previous difficulty with freezing?	Y N	Do injuries or cuts take a long time to heal?	Y N
Are you aware of any clenching/grinding habits?	Y N	Do you bruise easily or bleed a lot when injured?	Y N
Do you wear a nightguard appliance?	Y N	Are you interested in sedation?	Y N
Are your teeth sensitive to hot, cold, or sweet?	Y N	Are you a smoker?	Y N

When was your last dental examination by a dentist? _____

When was the last time that you had dental x-rays taken? _____

When was your last dental cleaning by a dental hygienist? _____

What causes you anxiety at the dental office? _____

Do you have any concerns regarding the appearance or functioning of your teeth? _____

☐ I understand that photographs and "selfies" are not permitted in the dental operatory.

By signing this form, I state that all the above information provided is true and complete to the best of my knowledge, and I am giving my consent for the Doctors and staff of Dedicated Dental Care to complete examinations and treatment on myself (or my dependent, as indicated) that is discussed and agreed upon by myself (the undersigned) and Doctors Kanda/Nicholls. I understand that all account balances are due upon day of service and that Dedicated Dental Care does not maintain an assigned benefits relationship with any insurance companies. All fees are between myself (the patient) and Dedicated Dental Care directly.

Patient/Guardian Signature: _____ Date: _____

Dedicated Dental Care Staff: _____ Date: _____