

Skyview Dental

Surname: _____ Given Name(s): _____
Birthday: _____ (m/d/y) Marital Status: Single Married Divorced Common Law
Street Address: _____ City: _____ P.C: _____
Phone #: Home _____ Business _____ Other _____
Employed By: _____ Do you have dental insurance? YES NO

If you are covered as a dependent under a spouse dental plan please provide:

Name of Spouse _____ Spouse Birthday: _____ (m/d/y)
Name of previous dentist/dental office: _____ Phone: _____
How did you hear about our office? _____

MEDICAL HISTORY:

Alberta Health Care #: _____ Physician: _____ Phone: _____

1. Are you currently taking any prescription medication? YES NO If yes, please indicate below:

2. Have you ever experience any unusual reactions to any of the the following? (please *J*)
 Antibiotics (Penicillin) Aspirin Codeine Local Anaesthetics (Freezing) Latex
3. Do you bruise/bleed easily or heal slowly? YES NO
4. Have you ever had any major surgery, radiation therapy or cortisone therapy? YES NO
*If yes, please specify (include date(s)): _____
5. Are you on any special diet? YES NO *If yes, please specify: _____
6. Have you ever had or been treated for any of the following diseases? (Please *J*):
 Diabetes Abnormal Blood Pressure Heart Attack or Heart Disease or Pacemaker Stroke
 Epilepsy Cancer Thyroid Disease Kidney Disease Liver Disease Mental or Nervous Disease
 Arthritis Tuberculosis Lung Disorders Sinus Problems Stomach Problems Ulcers
 Gall Bladder Hepatitis or Jaundice HIV/AIDS Back Problems Anemia Artificial Joints
 Respiratory Disease Fainting Other (please specify) _____
7. Is there any history of family disease? If so, what? _____
8. Women: Are you pregnant? YES NO If YES, how many months? _____

DENTAL HISTORY:

1. How often do you visit the dentist? Regularly Periodically Seldom
2. Do you ever experience any sensitivity to: Hot Cold Sweet Brushing Chewing/Pressure
3. Have you ever noticed bleeding gums? YES NO
4. How often do you: Brush your teeth? ___x/day Floss your teeth? ___x/week
5. Do you clench or grind your teeth? YES NO I DON'T KNOW
6. Do you ever experience pain in your jaw or "clicking" when opening/closing your mouth? YES NO
7. Do you smoke? YES NO
8. Other Dental Concern(s): _____

Patient Signature: _____

Date: _____