**PATIENT INFORMATION**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_ Health Card # \_\_\_\_\_

Town: \_\_\_\_\_\_\_\_ Prov: Postal Code: \_\_\_\_\_

Home Ph: ( ) \_\_\_\_ Cell Ph: ( ) \_\_\_\_\_

Emergency Contact: Phone: ( ) \_\_\_\_\_

**DENTAL COVERAGE**

* Do you have Dental Coverage under government assistance? Social Assistance / MSI / NIHB / Veteran’s Affairs
* Do you have Dental Insurance? Yes / No *(fill out the lines below, or provide info to reception desk)*

 Primary Policy Owner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Do you have a regular dentist? Name: \_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_\_

Can Fundy Dental Centre send clinical notes and x-rays from this visit to your dentist? Yes / No

Do visits to the dentist make you nervous? *(circle one)* Not at all / Moderate / Extremely

**MEDICAL HISTORY**

**PERSONAL HEALTH:**

* Do you smoke/vape? Yes / No
* Do you drink 10+ alcoholic beverages per week? Yes / No
* Allergies to medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are you taking any medications? Please list or provide a list: \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_
* Are there medical conditions that you are being treated for at this time? \_\_\_\_\_ \_\_\_\_\_
* Do you have a history of, or present issue with:

**□** Heart Attack  **□** Stroke **□** Other Heart Condition **□** High Blood Pressure **□** Diabetes **□** Asthma / COPD / *other*

**□** Prolonged Bleeding or Disorder **□** Liver / Kidney Issues  **□** Cancer / Tumor: Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Migraines **□** Hive **□** Psychiatric Treatment  **□** Drug Abuse **□** Other Conditions: \_\_\_\_\_

* Do you have any infectious diseases, such as:STD / HIV / AIDS / HEP C / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**: Health Conditions, re:Heart / Lung / Bleeding / Cancer : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all preceding answers are true and correct. Please inform your dentist of any change in health or medications. Also, please review our **Privacy and Consent Statement** in the waiting area. Exam (Office Only)

Signed: for: HR: \_\_\_ Temp: \_\_

Date: BP: X-ray: \_\_