TRI CITY DENTAL CENTRE
MEMBER OF
CONFIDENTAL

Medical Alert

Personal Information

- Patient's Name.....
  Last First Middle

- How do you want to be addressed..... - Male Female No preference

- Date of Birth (mm / dd / yyyy) ..... / ..... / ..... - Single Married Others

- Parent/Guardian (for minor patient)..... Father Mother Guardian

Address

Suite #..... Street.....

.....City..... Postal Code.....

Email.....

Phone

Home.....

Business.....

Cell.....

Emergency Contact Information

Name.....

Relation.....

Phone.....

- Other family member in this office?.....
- Whom may we thank for this referral?.....
- Who responsible for this account? .....

Dental Insurance Information

- Do you have any dental coverage?..... (If yes please provide to the office)
- Do you have second coverage thru another family member?.....(If yes please provide to the office)

Consent to Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part by my dental care payor.
I attest to the accuracy of the information on this page and my medical and dental history.

Patient's or Guardian's signature..... Date.....

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MEDICAL HISTORY

Patient's Name.....

Medical Doctor's Name..... **Phone or Address**.....

Please Circle around the appropriate answers

1 - Are you under the care of physicians? **Yes** **No**

If YES, Since when ..... **Why** .....

2 - Have you been hospitalized for any illness or operations? **Yes** **No**
If YES, When ..... **Why** .....

3 - Are you taking any medications or substances? **Yes** **No**
If YES, please list them

4 - Have you ever been advised to take antibiotics before dental appointments? **Yes** **No**
If YES, Why?

5 - Do you currently take blood thinners (Warfarin, Aspirin or Others)? **Yes** **No**
If YES, please list them

6 - Have you ever bled excessively after being cut or injured? **Yes** **No**

7 - Do you have any Allergy or Unusual Reaction to Penicillin, antibiotics or Anesthetics? **Yes** **No**

8 - Do you have or have you ever had any of the following? Mark with an (X)

	Chest Pain		Bronchitis / Emphysema		Kidney Problems
	Heart Attack		Allergy to Medications, Food or Substances		Depression
	Stroke		Hepatitis		Epilepsy / Seizure
	High Blood Pressure		Tuberculosis		Radiation / Chemo Treatment
	Heart Valve Problem		Rheumatic Fever		Blood Disorder Anaemia/Leukaemia
	Low Blood Pressure		Aids / HIV		Venereal Disease
	Diabetes		Stomach Problems		Joint Replacement
	Asthma		Liver Problems		Smoking

9 - For WOMEN, Are you pregnant or suspect you may be? **Yes** **No**
If YES, what is the expected delivery date?

10 - Are there any conditions or disease not listed above that you have or have had? **Yes** **No**
If YES, please list them

11 - Is there anything else we should know about your health that we have not covered in this form?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's/Guardian's signature..... **Date** .....

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DENTAL HISTORY

Patient's Name:.....

1 - Purpose of Visit, (What condition concern you at present)? Please mark with an (X)

	Regular Check Up		Cleaning		Toothaches Tooth Sensitivity
	Tooth Decay / Cavities		Chipped / Broken / Cracked Tooth		Gums Bleeding / Disease
	Unattractive Smile Cosmetic Dentistry		Stained Teeth / Whitening		Grinding / Clenching
	Missing Teeth		Wisdom Tooth Impacted Teeth		Bad Breath / Halitosis
	Crooked Teeth Orthodontic Treatment		Invisalign		Botox
	Food Trap between Teeth		Muscles Pain or Soreness		Jaw Clicking
	Mouth Sore				Other

2 - Your last dental visit? .....

Pervious Dentist:..... **Phone:**.....

Did you have cleaning then? **Yes** **No**

3 - Do you brush daily? **Yes** **No**

Do you floss daily? **Yes** **No**

4 - Do you have Oral Habits? (Grinding, Clenching or Other) **Yes** **No**

5 - Do you have or have you ever had any of the following? Please mark with an (X)

	Gum Treatments/Surgery		Root Canal		Implant
	Bridge		Crown / Veneer		Denture
	Night Guard		Orthodontic Treatment		Sedation Dentistry
	Jaw Surgery				Other

7 - Are there any conditions or problems not listed above that you have or have had? **Yes** **No**
(If YES, please explain)

8 - Have you ever had any problems or complications with previous dental treatment? **Yes** **No**
(If YES, please explain)

9 - Are you unhappy with the appearance of your teeth? Would you like a smile brighter? **Yes** **No**
(If YES, please explain)

10 - Is there anything else we should know about your teeth that we have not covered in this form?
(If YES, please explain) **Yes** **No**

Patients/Guardian's signature:..... **Date:** .....