Tooth Suite Family Dentistry
5019 47 Street, Lloydminster, Alberta T9V 0E8
toothsuitefamilydentistry.com
toothsuite@shaw.ca
Phone: 780.875.4312 Fax: 780.875.0300

Patient Profile

Patient Information

Surname		Given Name		Preferred Name	
Birthday (mm/dd/yyyy)		Age		Male ☐ Female ☐ Prefer not to say ☐	
Address / Box					
City		Province		Postal Code	
Home Phone		Cell Phone		Work Phone	
Email		Preferred Contact Method		Text ☐ Email ☐ Phone ☐	
Name of Spouse				Spouse Birthday	
Emergency Contact		Relationship		Phone	

Guardian

Guardian / Father Surname		Given Name		Birthday	
Guardian / Mother Surname		Given Name		Birthday	

Insurance

Person Responsible for Paying Account					
Name of Primary Insurance		Employer			
Group Policy Number		Phone		Division	
Name of Policy Holder					
Name of Secondary Insurance		Employer			
Group Policy Number		Phone		Division	
Name of Policy Holder					

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. We do require the following questionnaire to be filled out in its entirety. All information will be kept strictly confidential.

Alberta Health Care # _____

1. Are you currently under the care of a physician? Yes ☐ No ☐
   If so, what conditions are being treated?

2. Physician's name: _____
3. Have you been hospitalized, had a serious illness or operation in the past two years? Yes ☐ No ☐
   If so, what was the problem?

4. Are you taking any medications? Yes ☐ No ☐
   If so, please list medications:
   Pharmacy: _____

Medication		Purpose	
Medication		Purpose	
Medication		Purpose	
Medication		Purpose	

5. Do you use tobacco of any type? Yes ☐ No ☐
   If so, what type, how much and how long?

6. Do you use a vape? Yes ☐ No ☐
   If so, how many mg of nicotine and how long?

7. Please list all allergies

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8. Do you have any of the following? Please check all that applies.

☐ AIDS / HIV Positive	☐ Epilepsy / Seizures	☐ Mental Disorder
☐ Alzheimer's Disease	☐ Excessive Bleeding	☐ Multiple Sclerosis
☐ Anemia	☐ Fainting Spells / Dizziness	☐ Nervous Disorders
☐ Angina	☐ Frequent Cough	☐ Osteoporosis
☐ Arthritis / Gout	☐ Frequent Headaches	☐ Pacemaker
☐ Artificial Heart Valve	☐ Gastro-Intestinal	☐ Radiation Treatments
☐ Artificial Joints	☐ Glaucoma	☐ Respiratory Problems
☐ Asthma	☐ Heart Attack / Failure	☐ Rheumatic Fever
☐ Bacterial Myocarditis	☐ Hemophilia	☐ Sinus Trouble
☐ Blood Disease	☐ Hepatitis A ☐ B ☐ C ☐	☐ Sleep Apnea or Cpap machine
☐ Bruise Easily	☐ High Blood Pressure	☐ Stomach Problems
☐ Cancer - Type:	☐ High / Low Cholesterol	☐ Stroke
☐ Chemotherapy	☐ Hypoglycemia	☐ Thyroid Disease
☐ Chest Pains	☐ Irregular Heartbeat	☐ TMJ Problems
☐ Cold Sores / Fever Blisters	☐ Kidney Problem	☐ Tuberculosis
☐ Congenital Heart Disorder	☐ Leukemia	☐ Ulcers
☐ Diabetes - TYPE I ☐ TYPE II ☐	☐ Liver Disease	
☐ Emphysema	☐ Low Blood Pressure	

9. Have you ever had any serious illness not listed above? If so, what was it?

10. Are you pregnant? Yes ☐ No ☐ Due date: _____

11. Have you ever been treated for problems of our jaw or facial muscles? Yes ☐ No ☐

12. Are you aware of any of the following? Check all that applies.

☐ Clenching ☐ Grinding ☐ Cheek Biting ☐ Nail Biting
☐ Lip Biting ☐ Mouth Breathing ☐ Headaches ☐ Neck Aches
☐ Jaw Joint Popping ☐ Jaw Joint Clicking ☐ Jaw Joint Grating

To the best of my knowledge, the questions on this form have been accurately answered. I understand, it is my responsibility to inform Tooth Suite Family Dentistry of any changes to my medical status.

_____ _____ _____
Patient or Guardian Print Name Signature Date

Please attach any or all Prescription Information with this record.