



Patient Profile

Patient Information

Surname		Given Name		Preferred Name	
Birthday <small>(mm/dd/yyyy)</small>		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	
Certificate Identification Number					
Name of Policy Holder					
Name of Secondary Insurance		Employer			
Group Policy Number		Phone		Division	
Certificate Identification Number					
Name of Policy Holder					



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

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.