



First Name: _____
 Last Name: _____
 Prefers: _____
 Date of Birth: Day ___ Month _____ Year _____
 Address: _____
 City: _____
 Province: _____ Postal Code: _____
 Home Phone: _____
 Cell Phone: _____
 Business Phone: _____

E-mail: _____
 Employer: _____
 Occupation: _____
 In case of emergency, please notify: _____ Phone _____

- Referred by:
- Friend
 - Newspaper
 - Flyer
 - Walk-in
 - Other

MEDICAL HISTORY

- My last medical examination was on (approximate) _____
- Are you under the care of a physician? YES NO
- Name of Physician: _____ Address: _____
- Have you been hospitalized within the last 5 years? YES NO If yes, please explain why: _____
- Are you currently taking any medication, prescription or non-prescription? Please list:
 Drug: _____ Purpose: _____ Drug: _____ Purpose: _____
 Drug: _____ Purpose: _____ Drug: _____ Purpose: _____
- Have you been told that you require antibiotic prophylaxis before dental visits? YES NO
- Indicate which of the following you presently have or ever had:

YES	NO		YES	NO		YES	NO	
		<u>Infectious Diseases</u>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Bowel disease
<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S./+ve HIV test	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Frequent vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	Follow a special diet
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Loss/gain 10lbs or more/yr.
		<u>Musculoskeletal Condition</u>			<u>Hematological Disorders</u>			<u>Other Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Smoker
<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	History drug/alcohol abuse
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant
		<u>Neural Disorders</u>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or tumour
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy of seizures	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting			<u>Respiratory Diseases</u>			<u>Sensitivities/Allergies</u>
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin allergy
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to other medications
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic
		<u>Endocrine Disorders</u>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Food
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Metal
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/steroid therapy	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
		<u>Cardiovascular Diseases</u>			<u>Gastrointestinal Disorders</u>			If Yes to any of the above, does it result in swelling, shortness of breath or chest constrictions?
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Reflux esophagitis	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart defect			<u>Gastrointestinal Disorders</u>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant Week# _____
<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Reflux esophagitis	<input type="checkbox"/>	<input type="checkbox"/>	Nursing
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	

8. Do you have any diseases, conditions, or problems not listed above that you think we should know? YES NO

Please indicate: _____

DENTAL HISTORY

1. Have you had a dental exam in the last year? Last Visit? _____

2. When was your last dental x-rays? _____

3. Do you have any oral habits such as grinding your teeth, clenching or nail biting? _____

4. Do you have/use a night guard? _____

5. How often do you brush your teeth? _____ /day Floss you teeth? _____ /week

6. Do any of your teeth hurt? Broxen? Sensitive? _____

7. Do your gums bleed while you brush? _____

8. Do you have pain when you chew? _____

9. Do you have bad breath? _____

10. What concerns do you have? _____

11. How can we help to improve your smile? _____

12. Which one of the following would like to know more about:

- | | | | |
|--|-----------------------------------|---|---|
| <input type="checkbox"/> Botox & Fillers | <input type="checkbox"/> Implants | <input type="checkbox"/> Whitening | <input type="checkbox"/> Smile Makeover |
| <input type="checkbox"/> Invisalign | <input type="checkbox"/> Veneers | <input type="checkbox"/> Sedation Dentistry | <input type="checkbox"/> Children's Dentistry |

I, _____ do hereby consent to the release of dental and medical information, including clinical records and x-rays relative to my health care to Mint Dental. I authorize the release, to my insuring company plan administrator, the corresponding fees. I acknowledge that any fees **not** paid by my insurance company are my responsibility and estimates are subject to change due to unforeseen treatment. I am aware that Mint Dental will bill my insurance as a courtesy; however they are not responsible for my plan and may not know my information due to the privacy act of B.C. I understand that a possibility of complications exists for each treatment. In addition, **48 hours notice is required for appointment change** otherwise a \$75 cancellation fee will apply.

Date: _____

Siganture: X _____