Welcome to the Wembley Dental Clinic

Last Name	First	Initial	Date of Birth D. M. Y.
Address			
City/Province	Title (Mrs.) (Mr.) (Ms.) (Miss)		Postal Code

Telephone Residence	Business	Pager/Cell
Occupation	Employer	E-mail
Whom May We Thank For Referring You?	Emergency Contact Name	Emergency Contact Number
Person Responsible For Account		Do You Have Dental Insurance? ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Name Of Insured Date of Birth	Name Of Insured Date of Birth
Employer	Employer
Insurance Carrier	Insurance Carrier
Group/ Policy Number Division	Group/ Policy Number Division
I.D. Number or S.I.N.	I.D. Number or S.I.N.
Certificate Number	Certificate Number
Coverage Percentage A B C D	Coverage Percentage A B C D
Limits Basic Major Ortho	Limits Basic Major Ortho
Deductible ☐ Per Person Basic Major ☐ Per Family	Deductible ☐ Per Person Basic Major ☐ Per Family

Health Questionnaire

To help ensure your well being while receiving treatment in our office, please answer the following questions. All information will be considered confidential and for our records only.

General: **Please Circle**

1. Have you been examined and/or treated by a physician in the last year? **Yes No**
   Physician's Name _____ Physician's Phone _____
2. Have you ever been seriously ill or hospitalized? **Yes No**
   If so, what? _____
3. Have you ever experienced abnormal bleeding associated with previous extractions, surgery or trauma? **Yes No**
4. Are you taking any medication or non-prescription drugs now? **Yes No**
   What? _____

Please check (✔) if you have or have had any of the following?

SPECIFIC

- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Congenital heart condition
- ☐ Heart attack
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Rheumatic heart disease
- ☐ Angina pectoris
- ☐ Blood pressure problems
- ☐ Heart trouble
- ☐ Lung/ breathing problems
- ☐ Kidney/ bladder problems
- ☐ Stomach/ intestinal problems
- ☐ Stomach ulcers
- ☐ Hepatitis/ jaundice
- ☐ Liver disease
- ☐ Diabetes
- ☐ Blood disorders
- ☐ Pacemaker/ artificial valves
- ☐ Artificial joints/ implants
- ☐ Infectious/communicable disease
- ☐ Venereal disease
- ☐ AIDS
- ☐ Tuberculosis
- ☐ Positive testing for HIV
- ☐ Tumours or growths
- ☐ Nervous/ mental problems
- ☐ Epilepsy
- ☐ Thyroid disease
- ☐ Cortisone/ steroid therapy
- ☐ Anemia
- ☐ Cancer of any type
- ☐ Radiation Therapy
- ☐ Arthritis

ALLERGIES

- ☐ Hives/ skin rash
- ☐ Asthma
- ☐ Hay fever
- ☐ Allergies _____
- ☐ Unusual reaction to any drug _____

SYSTEMS REVIEW

- ☐ History of family disease
- ☐ Prolonged bleeding
- ☐ Bruise easily
- ☐ High risk group for AIDS
- ☐ Severe headaches
- ☐ Sinus Trouble
- ☐ Earaches
- ☐ Trouble hearing
- ☐ Sore throats
- ☐ Shortness of breath
- ☐ Chest pains
- ☐ Swollen ankles
- ☐ Heart palpitations
- ☐ Extra pillows for sleep
- ☐ Persistent cough
- ☐ Blood in sputum
- ☐ Recent change of appetite
- ☐ Foods that you cannot eat
- ☐ Difficulty in swallowing
- ☐ Frequent indigestion/ vomiting
- ☐ Feel thirsty much of the time
- ☐ Urinate more than 6 times/ day
- ☐ Painful/ swollen joints
- ☐ Numb/ prickling sensations
- ☐ History of broken bones
- ☐ Tendency to faint
- ☐ Fits, seizures or convulsions

HABITS

- ☐ Tobacco
- ☐ Alcoholic beverages
- ☐ Non prescription drugs
- ☐ Other

WOMEN ONLY: Are you

- ☐ Pregnant (how many months _____)
- ☐ Past menopause

Is there anything concerning your health that you think the doctor should know about? Yes No

If so, what? _____

By signing below, I understand and authorize that my insurance information may be sent electronically. I also consent to the dental treatment agreed upon and that I am responsible for payment of the corresponding fees. I understand that a possibility of complications exists for each treatment.

Date _____ Signature _____

☐ Patient ☐ Parent ☐ Guardian