In order to render the best professional care, it is necessary that we become acquainted with the vital information related to each patient. Of course all information is strictly confidential. At Olympia Dental, we appreciate your cooperation in filling out this form carefully and accurately.

			Date
Patient's Last Name	Mr. Mrs. Dr. Ms.	Given Names	Home Phone
Apt. Address		City	Postal Code
Date of Birth month — day — year		Email	Reason for today's visit ☐ Examination ☐ Emergency
Occupation		Employer	Business Phone

In case of emergency notify	Relationship	Phone
Name of person responsible for your account ☐ Self, Other:	Whom may we thank for referring you? Name:	

Do you have Dental Insurance?	Name of Insured Employee	Insurance Company	Employer
	Group Policy Number	Certificate or I.D. Number	
Policy Holder Date of Birth			

Family Physician	Phone	Previous Dentist	Address or Phone

MEDICAL HISTORY

	Yes	No
★ Is your physician currently treating you for any reason?	☐	☐
If yes, explain_____		
★ Have you ever been hospitalized?	☐	☐
If yes, specify_____		
★ Have you ever had a general anaesthetic?	☐	☐
Any problems?_____		
★ Do you bruise easily of bleed excessively when cut?	☐	☐
★ Are you currently taking any pills, drugs or other medicines?	☐	☐
If yes, please list: 1._____ 2._____		
3._____ 4._____		
★ Have you ever taken cortisone, steroids, anti-depressants, blood thinners, or thyroid medicine?	☐	☐
★ Do you smoke tobacco products?	☐	☐
★ Women, are you pregnant? If yes, when do you expect? _____		
★ Do you have any or have you ever had any of the following?		

- ☐ 1. Heart disease or chest pains
- ☐ 2. High blood pressure
- ☐ 3. Heart murmur
- ☐ 4. Pacemaker or artificial valves
- ☐ 5. Rheumatic fever
- ☐ 6. Diabetes
- ☐ 7. Blood disorders or anemia
- ☐ 8. Lung or breathing problems
- ☐ 9. Asthma
- ☐ 10. Kidney or liver problems
- ☐ 11. Hepatitis
- ☐ 12. Thyroid problems
- ☐ 13. Stomach or intestinal problems
- ☐ 14. Tuberculosis
- ☐ 15. Arthritis
- ☐ 16. Artifical joint replacements
- ☐ 17. Epilepsy or seizures
- ☐ 18. Syphilis, gonorrhea, AIDS
- ☐ 19. Tumours or cancer
- ☐ 20. Radiation therapy
- ☐ 21. Shortness of breath

Please specify:_____

★ Is there anything else concerning your health the doctor should know? _____

★ Are you allergic to any medications or drugs?	☐	☐
If yes, explain _____		
★ Do you have any other allergies?	☐	☐
If yes, to what? _____		

Over ▶

DENTAL HISTORY

★ Approximate date of last dental checkup? _____

★ Have you ever had any of the following:

- ☐ 1. Fillings
- ☐ 2. Regular cleanings
- ☐ 3. Recent dental X-rays
- ☐ 4. Nitrous oxide (laughing gas)
- ☐ 5. Periodontics (gum treatment)
- ☐ 6. Caps or crowns
- ☐ 7. Extractions
- ☐ 8. Root canal treatment
- ☐ 9. Full or partial dentures
- ☐ 10. Orthodontics (braces)
- ☐ 11. An injury to your mouth or jaws

	Yes	No
★ Have you ever had a local anaesthetic?	☐	☐
If yes, any problems? _____		
★ Have you ever had an 'unfavourable' dental experience?	☐	☐
If yes, explain _____		
★ Would you be interested in having nitrous oxide (laughing gas) during appointments?	☐	☐
★ Do you get 'cold sores' or 'mouth ulcers'?	☐	☐
If yes, how often? _____		

SMILE ANALYSIS

★ Are you reluctant to show your teeth when you smile?	☐	☐
★ Are there any gaps or spaces between your teeth which you are concerned about or would like to change?	☐	☐
★ Are there any stains on your teeth which you would like removed or lightened?	☐	☐
★ Do you have any chipped or broken teeth which you are concerned about or would like to change?	☐	☐
★ Is there anything about your smile which you would like to change?	☐	☐
★ Do you have any teeth that are crooked or misaligned which you are concerned about or would like to change?	☐	☐
★ Would you like to have whiter teeth?	☐	☐
★ Would you like to maintain and keep your natural teeth for a lifetime?	☐	☐

★ Do you presently have or think you may have any of the following:

- ☐ 1. Loose teeth
- ☐ 2. Cavities
- ☐ 3. Gum disease
- ☐ 4. Sensitive teeth
- ☐ 5. Bleeding gums
- ☐ 6. A bad taste in your mouth
- ☐ 7. A clicking or sore jaw
- ☐ 8. Earaches or headaches
- ☐ 9. Unsightly or broken fillings
- ☐ 10. Dead or abcessed teeth

★ In your own words, describe your present dental problem or needs: _____

_____

OFFICE PHILOSOPHY AND POLICY: (please read)

★ In an effort to determine a treatment plan that is best for your overall dental health, we must make a careful diagnosis. This involves a thorough examination, often utilizing the minimum number of X-rays necessary for accuracy.

★ We pledge to provide high quality dentistry in the most comfortable manner possible, with the best equipment, materials and up to date techniques.

★ The longterm success of our efforts will depend on the patients' willingness to maintain their teeth and prevent any future dental problems.

★ Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require 48 hours notice. Failure to do so will result in a fee. The amount will be determined by the length of your appointment.

★ Our office policy is that services are paid for at each visit as they are performed. In certain circumstances, financial arrangements for payment may be made by consulting the doctor or receptionist.

★ **Regarding insurance:** All patients with dental insurance are responsible for payment of their own accounts. We are pleased that you have insurance to reimburse or minimize your personal expenditure and we will gladly complete any claim forms to assist you in collecting your dental benefits. Please make certain you understand any limitations in your contract. We will gladly submit 'estimate' forms, if necessary.

★ All **urgent** dental problems will be attended to the same day, under normal circumstances. You may call our office or answering service at any time.

★ A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel relaxed and open to discuss with us, any aspect of your treatment or fees, at any time.

★★ We are pleased to welcome you to our practice, and hope to provide you, your friends and relatives with the highest quality of dental care.

CONSENT FOR TREATMENT

This is to certify that I consent to the performing of the dental procedures agreed to be necessary and I will assume responsibility for fees associated with those procedures.

_____ Date

_____ Signature (Parent or Guardian)