PATIENT INFORMATION

Welcome to **Cosmodont Dentistry**. To assist us in serving you, please complete the following confidential form.

Patient's name_____Preferred name _____Sex ____ Birth date_____

Home phone _____Cell phone _____ E-mail_____

Address_____ City _____ Prov.____ Postal Code_____

Employer/School _____ Occupation _____Work phone_____

Spouse's name _____Spouse's employer _____ ☐ Unmarried

Whom may we thank for referring you to our office? _____

EMERGENCY CONTACT NAME _____RELATION _____PHONE _____

DENTAL HISTORY

Reason for today's visit _____ Former Dentist Name _____

Date of last dental visit _____ Date of last cleaning _____ Date of last dental x-ray _____

Do you have or have you had any of the following? (Please check any that apply)

- o Issue with previous treatments
- o Bad breath
- o Bleeding gums
- o Blisters on lips or mouth
- o Chew on one side of mouth
- o Smoking
- o Clicking or popping jaw
- o Denture
- o Food collection b/t teeth
- o Grinding teeth
- o Gums swollen or tender
- o Jaw pain or tenderness
- o Loose teeth or broken filling
- o Mouth breathing
- o Orthodontic treatment
- o Pain around ear
- o Periodontal treatment
- o Sensitivity to cold/heat/sweets

Do you have any dental related issues/concerns not listed above? _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

(Please check any that apply)

- o Cancer or tumor
- o Heart disease
- o Artificial joint or valve
- o Pacemaker
- o Tuberculosis or other lung problems
- o Kidney disease
- o Hepatitis or other liver disease
- o Alcoholism
- o Blood transfusion
- o Diabetes
- o Neurologic condition
- o Epilepsy, seizures, or fainting spells
- o Emotional condition
- o Arthritis
- o Herpes or cold sores
- o AIDS or HIV positive
- o Migraine headaches or frequent headaches
- o Anemia or blood disorders
- o Abnormal bleeding after extractions, surgery, or trauma
- o Hay fever or sinus trouble
- o Allergies or hives
- o Asthma

Are you allergic to, or have you reacted adversely to:

- o Latex materials
- o Penicillin or other antibiotics
- o Local anesthetics (''Novocain")
- o Codeine or other narcotics
- o Barbiturates, sedatives, or sleeping pills
- o Aspirin
- o Other:_____

Are you taking any of the following?

- o Aspirin
- o Anticoagulants(blood thinners)
- o Antibiotics or sulfa drugs
- o High blood pressure medicine
- o Antidepressants or tranquillizers
- o Insulins, Orinase, or other diabetes drug
- o Nitroglycerin
- o Cortisone or other steroids
- o Osteoporosis (bone density) medicine
- o Other:_____

Women:

- o Maybe pregnant, expected due date
- o Taking hormones or contraceptives

Name of your physician: _____**Phone number**_____

Do you have any disease, condition, or problem not listed above? _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance.

Signature of patient (or parent)

Signature_____ **Date** _____