FIRST NAME _____ LAST NAME_____PRONOUN: _____DATE _____

ADDRESS _____
Street Number Street Name City Province Postal Code

HOME Phone #_____ MOBILE Phone #_____ OFFICE Phone #_____

EMAIL Address _____ DOB _____ AGE_____ Gender Identity _____

PATIENT Occupation _____ HEALTH CARD #_____

Emergency Contact Name _____ Phone #_____ Relationship _____

Name/Phone# of DENTIST _____/_____ Name/Phone# of FAMILY Dr. _____/_____

WHO referred you here? _____ WHY are you here today? _____

PERSON RESPONSIBLE for PAYMENT of OFFICE FEES

Name _____Relationship to Patient _____ Phone #_____

Method CASH DEBIT E-TRANSFER Certified Cheque VISA MASTERCARD AMEX - Not Accepted

Do you have Private DENTAL INSURANCE NO YES If Yes, please provide the information to receptionist

Do you hold Government Dental Welfare Benefits? NO YES If Yes, please provide the information to receptionist

Are you currently under the Care of Doctor and/or Specialist ? NO YES Why?_____

List Drug, Food and Environmental Allergies. NONE YES _____

List ALL Drugs and Dosages, include Prescription Drugs, Recreational Drugs, Herbal Medicines and Blood Thinners NONE YES

_____

Do you Smoke Cigarettes, Cannabis, or Vape? NO YES _____/day. Do you drink Alcohol? NO YES _____ oz/wk.

List Hospitalizations. NONE YES Date/Reason_____

List Operations/General Anesthesia. NONE YES Date/Reason_____

Heart Disease	NO	YES	Shortness of Breath	NO	YES	Anemia or Sickle Cell	NO	YES	Dementia	NO	YES
Chest Pain or Angina	NO	YES	Sinus Disease	NO	YES	Prolonged Bleeding	NO	YES	Osteoporosis	NO	YES
Heart Attack or Stroke	NO	YES	Stomach Ulcers	NO	YES	Blood Transfusion	NO	YES	Bone Drugs	NO	YES
Heart Murmur/MVP	NO	YES	Bowel Disease	NO	YES	Malignant Hyperthermia	NO	YES	Hemophilia	NO	YES
Rheumatic Fever	NO	YES	Liver Disease	NO	YES	STD's/HIV/AIDS	NO	YES	Contact lenses?	NO	YES
Heart Defects	NO	YES	Hepatitis A B C	NO	YES	Sleep Apnea/CPAP	NO	YES	Women:		
High Blood Pressure	NO	YES	Jaundice	NO	YES	Arthritis	NO	YES	Pregnant?	NO	YES
Circulation Problems	NO	YES	Thyroid Disease	NO	YES	Headaches	NO	YES	What month?	_____	
Asthma	NO	YES	Kidney Disease	NO	YES	Facial injury	NO	YES	Nursing?	NO	YES
Bronchitis/Pneumonia	NO	YES	Diabetes Type I or II	NO	YES	Cancer	NO	YES	Birth Control Pill?	NO	YES
Persistent Cough/Cold	NO	YES	Seizures/Epilepsy	NO	YES	Psychiatric Care	NO	YES	_____		
COPD/Lung Disease	NO	YES	Parkinson's Disease	NO	YES	Eating Disorders	NO	YES	_____		

List Prosthetic Devices: Pacemaker Artificial Joints Dental Implants Dentures NONE

Do you require Antibiotic Pills before Dental Procedures? NO YES Why? _____

Have you had any problems with dental freezing or tooth extractions? NO YES Why?_____

Orthodontic Care. NO YES In Progress? NO YES Year completed? _____ Name of Orthodontist_____

Problems with your Jaw Joints? Pain Limited Opening Clenching Grinding Habits NONE

Level of Dental Anxiety Not Anxious 0 1 2 3 4 5 6 7 8 9 10 Extremely Anxious

Is there any additional information you wish to tell Dr. Eidinger or her Staff? _____

Is permission given to discuss/email/release information to you/your Dentist/Dental Specialist/Doctor/Insurance Company? NO YES

CONSENT FOR TREATMENT: I, the undersigned, give consent for the performance of the contemplated and/or necessary procedures, and for the administration of local and/or sedative anesthesia, to Dr. Eidinger. I assume responsibility for the payment of all fees associated with these procedures. I understand that failure to do so will result in my account being sent to a "Collection Agency." By signing this form, I confirm that I have provided truthful information, and an accurate, complete and up- to- date medical health history.

Signature of Patient/Parent/Guardian_____ Print Name_____