

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 _____