Skyview Dental

Surname: ________________________________ Given Name(s): ____

Birthday: ____________________ (m/d/y) Marital Status: □ Single □ Married □ Divorced □ Common Law □Widowed

Street Address: ____________________________ City: ______________________ Postal Code: _____________________

Phone #: Home ______________________ Business ______________________ Other ______________________

Employed By: ____________________________________ Do you have dental insurance? □ YES □ NO

Email: ____

If you are covered as a dependent under a spouse or parent dental plan please indicate: □ Spouse □ Parent

Name of Spouse/Parent: ______________________________ Spouse/Parent Birthday: ______________________ m/d/y)

Employed By: _______________________________________

Name of previous dentist/dental office: _________________________________ Phone: ________________________

How did you hear about our office? ______________________________________

MEDICAL HISTORY:

Alberta Health Care #: _________________ Physician: _____________________________ Phone: __________________

1. Are you currently taking any prescription medication? □ YES □ NO *If yes, please indicate below(or provide a list):

   ____

2. Have you ever experienced any unusual reactions to any of the following? (please √)

   □ Antibiotics (Penicillin) □ Aspirin □ Codeine □ Local Anaesthetics (Freezing) □ Latex □ Ibuprofen

3. Have you been told you needed antibiotics before dental visits? □ YES □ NO

   History of: □ Heart Murmur □ Artificial Joints □ Transplants □ Immunosuppresive Therapy □ Rheumatic Fever

4. Do you bruise/bleed easily or heal slowly? □ YES □ NO

5. Have you ever had any major surgery, radiation therapy or cortisone therapy? □ YES □ NO

   *If yes, please specify (include date(s)): ____

6. Have been diagnosed with cancer? *If yes, have you done radiation or chemotherapy? □ YES □ NO

7. Do you have osteoporosis? □ YES □ NO *If yes, have you taken any medications for it? □ YES □ NO __________________

8. Have you ever had or been treated for any of the following diseases? (Please √):

   □ Diabetes □ High/Low Blood Pressure □ Heart Attack or Heart Disease or Pacemaker □ Stroke

   □ Epilepsy □ Cancer □ Thyroid Disease □ Kidney Disease □ Liver Disease □ Mental or Nervous Disease

   □ Arthritis □ Tuberculosis □ Lung Disorders □ Sinus Problems □ Stomach Problems □ Ulcers □ Asthma

   □ Gall Bladder □ Hepatitis or Jaundice □ HIV/AIDS □ Back Problems □ Anemia □ Artificial Joints

   □ Respiratory Disease □ Fainting □ Other (please specify) ___________________________________

9. Is there any history of family disease? If so, what? ____

10. Women: Are you pregnant? □ YES □ NO If YES, how many months? __________________________________

DENTAL HISTORY:

1. How often do you visit the dentist? □ Regularly □ Periodically □ Seldom
2. Do you ever experience any sensitivity to: □ Hot □ Cold □ Sweet □ Brushing □ Chewing/Pressure
3. Have you ever noticed bleeding gums? □ YES □ NO
4. When was your last dental cleaning? ____________________________
5. How often do you: Brush your teeth? ___x/day Floss your teeth? ___x/week
6. Do you clench or grind your teeth? □ YES □ NO □ I DON'T KNOW
7. Do you ever experience pain in your jaw or "clicking" when opening/closing your mouth? □ YES □ NO

8. Do you smoke? □ YES □ NO *If yes, how much? ____________How long have you been smoking? ___________

9. Other Dental Concern(s):____

Patient Signature: _________________________________ Date: _____________________________