SOUTH GEORGETOWN
DENTAL CARE

Please be advised all Information is private and confidential
Please be sure to bring your insurance information to your first visit

We welcome you to our dental practice.

Patient Information (Adult Information)

□ Mr □ Mrs □ Miss □ Ms

Name: _____
First Name Last Name

Address: _____

City: _____ Province: _____ Postal Code:_____

Date of Birth: Day_____Month_____Year_____

Phone #: **Home: _____** **Cell: _____**
Email:_____

Preferred Contact Method (Please circle one)	Text Email Call cell Call home	**How did you hear about us?** (please circle one)	Flyers Drive/Walk by Online Friends and family (who may we thank) _____ Other

Emergency Contact Information

Emergency Contact Name: _____
Phone: (____)_____ Relationship: _____

Today's Visit

Reason for this appointment? _____

Do you have dental insurance? □ Yes □ No

Your Medical History

Family Physician: _____ Phone Number: _____
Address: _____ City: _____ Postal Code: _____
Specialist: _____ Phone Number: _____
Date of your last physical exam: _____ Date of your last visit with your doctor: _____
Would you consider yourself to be in good health?: □ Yes □ No
Have you been hospitalized in the past 2 years? □ Yes □ No Reason: _____
Have you had any surgeries? Date and reason: _____
Do you smoke? □ Yes □ No
WOMEN only: Are you pregnant? □ Yes □ No

Please list all medications you are currently taking: _____

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Please turn over!

Medical Conditions

Please indicate any conditions you currently have or have had in the past:

□ Cancer
□ High Blood Pressure
□ Low blood pressure
□ Diabetes Type 1
□ Diabetes Type 2
□ Stroke
□ Heart Problems
□ Artificial Heart Valve
□ Mitral Valve Prolapse
□ Heart Attack
□ Blood / Bleeding Disorders
□ Angina Pectoris
□ Kidney Disease
□ Osteoporosis
□ Arthritis / Gout
□ Thyroid Disease
□ Pacemaker
□ AIDS (HIV)
□ Anemia
□ Asthma
□ Cold sores
□ Liver Disease (Hepatitis A, B, C)
□ Mental / Nervous Disorders
□ Fainting/ Dizziness
□ Sinus Trouble
□ Heart Palpitations
□ Epilepsy / Seizures
□ Malignant Hyperthermia
□ Crohn's Disease
□ Ulcers /Stomach concerns
□ Lung disease
□ Drug / Alcohol Addiction
□ Malignant Hyperthermia
□ Congestive Heart Failure
□ Bleeding disorder
□ Headaches
□ Hernia
□ Artifical Joints
□ Hip / knee replacement
□ Emphysema

Are you taking any blood thinners? *(Warfarin / Coumadin / Plavix / Aspirin / Other)* □ Yes □ No
List: _____
Are there any other medical concerns we should be aware of? _____
_____

Allergies and Reactions

Please indicate which medications or materials you are allergic to, or have had a reaction to in the past:

□ Aspirin (ASA)
□ Ibuprofen (ADVIL)
□ Acetaminophen (TYLENOL)
□ Codeine (TYLENOL 1, 2 or 3)
□ Percocet / Oxycocet
□ Tetracycline
□ Penicillin/Amoxicillin /Ampicillin
□ Erythromycin
□ Clindamycin
□ Local Anaesthetic (Freezing)
□ Latex
□ Nitrous Oxide
□ Chlorhexidine (PERIDEX)
□ Metal Allergy
□ Cephalosporins (KEFLEX)
□ Sulfa Drugs

Other drugs or material allergies not listed above; _____

Patient Signature: _____
Dentist Signature: _____
Date: _____

For office use only

Insurance info: Policy # _____ID# _____

Policy holder _____ Policy holder DOB _____