Maple Street
DENTAL

320 Maple Street
Fredericton, NB, E3A 3R4
Phone: (506) 458-8898
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Patient Information

Date: _____ **Name**_____ Date of Birth.___/___/____
M/D/Y

Home Phone #_____Work phone #_____Email:_____

Mailing Address_____ Prov._____ Postal Code_____

Occupation_____Employer_____

Spouse's Name: _____ Spouse's work phone #_____.

Referred by (name of friend, fellow employee, etc):_____

Family Doctor_____ Date of last physical examination_____

Dependent

Children only: Mother's Name_____ Work phone #_____

Father's Name_____ Work phone #_____

_____

MEDICAL HISTORY

Any Dental Concerns:_____

Please circle:

Yes	No	Are you having tooth, gum or head and neck pain or discomfort at this time?
Yes	No	Do you feel very nervous about having dental treatment?
Yes	No	Have you ever had a bad experience in a dental office?
Yes	No	Have you been a patient in a hospital during the past two years?
Yes	No	Have you been under the care of a medical doctor during the past two years?
Yes	No	Have you taken any medicine or drugs during the past two years?
Yes	No	Are you allergic (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine or any drugs or medications?
Yes	No	Have you ever had any excessive bleeding requiring special treatment?

Check any of the following which you have had or have at present:

Heart failure	Wheelchair Dependent	HIV
Heart Disease or Attack	Emphysema	Hepatitis
Angina Pectoris	Lung or breathing Problems	Liver Disease
High Blood Pressure	Tobacco use	Yellow Jaundice
Heart Murmur	Tuberculosis (TB)	Blood Transfusion
Rheumatic Fever	Asthma	Drug Addiction
Congenital Heart Defects	Hay Fever	Alcohol Abuse
Artificial Heart Valve	Sinus Trouble	Hemophilia
Heart Pacemaker	Allergies or Hives	Venereal Disease
Heart Surgery	Diabetes	(Syphilis, Gonorrhea)
Artificial Joint	Thyroid Disease	Cold Sores
Anemia	Cancer, Leukemia	Epilepsy or Seizures
Fainting or Dizzy Spells	X-ray or cobalt Treatment	Stroke
Kidney Trouble	Chemotherapy	Nervousness
Dialysis	Arthritis	Psychiatric Treatment
Ulcers	Rheumatism	Sickle Cell Disease
Headaches	Cortisone/Steroid Medicine	Bruise Easily
Mentally Handicapped	Glaucoma	Latex Sensitivity
Brain Injury	Pain in Jaw Joints	

Yes___ No___ When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are tired?

Yes___ No___ Have you lost or gained more than 10 pounds in the past year?

Yes___ No___ Do you ever wake up from sleep short of breath or sweating heavily?

Yes___ No___ Are you on a special diet? _____ Doctor's order or self imposed?

Yes___ No___ Has your medical doctor ever said you have a cancer or tumor?

Yes___ No___ Do you have any disease(s), conditions(s) or problems(s) not listed?

Women (a) Are you pregnant now? _____

(B) Do you take a birth control pill? _____

Please list all your current medications_____

_____

DENTAL HISTORY

Are you having dental pain? _____

Do you think you have gum problems? _____

Do you notice popping, clicking or soreness of the jaw or just in front of your ears? _____

Are you involved in any contact sports? (i.e. hockey, football, etc)_____

Have you ever had problems with dental freezing (local anesthetic)? ____

When was you last dental visit? _____ Were your last x-rays taken?_____

Do you wear complete or partial dentures? _____ How many years have you worn dentures? _____. How old are your present dentures? _____ Do you have a dry mouth? _____

I hereby consent to have Dr. Graham and her staff provide me with dental care as mutually agree upon. To the best of my knowledge, all of the preceding answers are true and correct. If, I ever have any change in my health, or if my medicine changes, I will inform the dental staff at the next appointment without fail.

_____ _____ _____

Date Patient's or Guardian signature Dentist's signature

Please note: 24 hour notice is required for any cancellation!