470 Hodder Avenue
Thunder Bay, Ontario P7A 7X5
(807) 683-5222

CONFIDENTIAL PATIENT HISTORY FORM

1. PERSONAL INFORMATION

Today's Date ______

Name Prefix ______ Last ______ First ______ Date of Birth ______

Street Address ______ Apt. # ______ City ______ Postal Code ______

Home Phone ______ Work Phone ______ Ext. ______

Occupation ______ Place of Business ______

Person responsible for account: ☐ Self Other: Full Name ______ Phone # ______

Address ______

Dental Insurance: ______ If "Yes": Policy Holder Name ______ Policy Holder Date of Birth ______

Insurance Company Name ______

Policy # ______ Group Plan # ______ Subscriber ID ______

In the event of an appointment opening, may we contact you at short notice? ______

In case of emergency, please notify: Name ______ Phone # ______ Relationship ______

Address ______

Physician's Name ______

Whom may we thank for referring you? ______ Address ______

2. DENTAL HISTORY

Do you have regular dental care? ______

When was your last visit to a dentist (approx)? ______ When was your last complete dental exam? ______

When was your last complete series of dental x-rays taken? ______ Name of previous dentist ______

Are you satisfied with the appearance of your teeth and smile? ______ Do you grind or clench your teeth? ______

Are you anxious to keep your remaining teeth? ______ Do your gums bleed on their own or when brushing? ______

Are you aware of any loose teeth? ______ Do your jaw joints crack, grind, pop or hurt? ______

Do you favor one side when chewing? ______

Are any of your teeth sensitive to ☐ Cold ☐ Heat ☐ Sweets Other? ______

How often do you brush your teeth? ______ How often do you floss your teeth? ______

Reason for your visit: ☐ Complete treatment ☐ Specific problem ☐ Emergency

Do you have an immediate dental concern? ______

On a scale from 1 to 10, choose a number that best describes your feelings toward dental treatment, where 1 = "calm and relaxed" and 10 = "extremely nervous and apprehensive" ______

Are you interested in any form of sedation for certain routine dental procedures? ______

If yes, above, how much does a single drink of alcohol (ie: glass of wine or bottle of beer) affect you? ______