CANYON DENTAL CENTRE

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential

PERSONAL INFORMATION

First Name:_____ Last Name:_____
Date of Birth (mm/dd/yyyy):_____ Sex: _____ Marital Status:_____
Address:_____ City:_____ Province: _____
Postal Code:_____ Home Phone_____ Cell Phone:_____
Work Phone:_____ Email Address:_____
Employer/School:_____ Full Time or Part Time (Circle)
Spouse, Partner or Parent name:_____
How did you learn about our practice and who may we thank for referring you?

_____
Who is responsible for your account and payment?
Name:_____ Date of Birth (mm/dd/yyyy):_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

DENTAL HISTORY

Reason for Today's Visit?_____
Date of Last Dental Care Visit?_____ Date of Last Dental X-Ray?_____
How Often Do You Floss?_____ How Often Do You Brush?_____
Do You Have Any Oral Habits Such as - Clenching, Grinding Your Teeth, or Nail Biting?

_____
Have You Ever Had Tooth Brushing/Flossing Instruction?_____
Are You Satisfied With the Function and Appearance of Your Teeth?_____
Are you interested in Learning About Teeth Whitening Systems?_____
Former Dentist's Name?_____ Phone:_____

Check If You Have or Have had Any of the Following:

- ☐ Bad Breath
- ☐ Bleeding Gums/Teeth
- ☐ Bridges
- ☐ Clicking or Popping Jaw
- ☐ Extraction(s)
- ☐ Food Collection Between Certain Teeth
- ☐ Full Dentures
- ☐ Grinding Teeth
- ☐ Gum treatments
- ☐ Injuries to Your Face or Jaws
- ☐ Loose or Broken Fillings
- ☐ Loose Teeth
- ☐ Lost Filling(s)
- ☐ Orthodontic Treatment
- ☐ Partial Dentures
- ☐ Periodontal Treatment
- ☐ Root Canal Filling
- ☐ Sensitivity to Any of the Following - Cold, Hot, Sweets
- ☐ Sensitivity When Biting
- ☐ Sores or Growth In Your Mouth
- ☐ Surgery in Your Mouth
- ☐ Swelling in Your Mouth or Jaws

What Dental Condition Concerns You Now?_____

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____
Parent or Gardian Signature Date

MEDICAL HISTORY

Your Physician:_____ Date of Last Visit:_____
Have you ever taken any of the drugs collectively referred to as "fen-pen?_____
Have you have any serious illnesses or operations?_____ If yes, describe:_____
Have you ever had a blood transfusion?_____ If yes, give approximate date:_____
Have you ever experienced abnormal bleeding associated with previous extraction, surgery, or trauma?
_____
Are you taking any medications or non-prescription drugs now?_____ Please List Below:
Medication_____ Diagnosis_____
Medication_____ Diagnosis_____
Medication_____ Diagnosis_____
Do you have any allergies?_____ Please list Below:
Allergy_____ Allergy_____ Allergy_____
Women: Are you pregnant?_____ Are you nursing?_____ Are you taking birth control?_____

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves or Pacemaker
- ☐ Artificial Joints, Pins, Implants, Etc.
- ☐ Asthma
- ☐ Bleeding Abnormally
- ☐ Blood Disease or Disorders
- ☐ Blood Pressure Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions or Problem
- ☐ Cortisone/Steroid Therapy
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Epilepsy
- ☐ Fainting
- ☐ Feel Thirsty Much of the Time
- ☐ Fits, Seizures, or Convulsions
- ☐ Food that You Cannot Eat
- ☐ Frequent Indigestion/Vomiting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur/Palpitations
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ History of Broken Bones
- ☐ History of Family Disease
- ☐ HIV AIDS
- ☐ Infectious/Communicable Disease
- ☐ Inflammatory Rheumatism
- ☐ Kidney Disease or Problems
- ☐ Liver Disease or Problems
- ☐ Lung/Breathing Problems
- ☐ Mitral Valve Prolapse
- ☐ Nervous/Mental Problems
- ☐ Numb/Prickling Sensations
- ☐ Painful/Swollen Joints
- ☐ Persistent Cough
- ☐ Radiation Treatment
- ☐ Recent Change in Appetite
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Severe Headaches
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Stomach / Intestinal Problems
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems or Problems
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Unusual Reaction to Any Drug
- ☐ Urinate More than 6 Times a Day
- ☐ Venereal Disease

DENTAL INSURANCE

Insurance Company:_____ Plan Holder's Name:_____
Date of Birth (mm/dd/yyyy):_____ Group #:_____ ID #:_____
How Much is Your Deductible?_____ What is Your Annual Maximum Benefit? _____
Basic %:_____ Prosthetic %:_____ Crown/Bridge %:_____ Orthopedic %:_____

SECONDARY DENTAL INSURANCE

Insurance Company:_____ Plan Holder's Name:_____
Date of Birth (mm/dd/yyyy):_____ Group #:_____ ID #:_____
How Much is Your Deductible?_____ What is Your Annual Maximum Benefit? _____
Basic %:_____ Prosthetic %:_____ Crown/Bridge %:_____ Orthopedic %:_____

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_____ _____
Parent or Gardian Signature Date