

Dr. Janet S. Leith, DMD

We appreciate referrals. Whom may we thank for referring you _____

DISPONIBLE EN FRANCAIS

Date _____

CONFIDENTIAL PATIENT INFORMATION

Your co-operation in completing **both** sides of this form is essential to help us provide you with the highest possible standard of dental care. All information is strictly confidential and will remain with this office.

NAME: _____
Last First Middle

ADDRESS _____
Apt Street City Prov. Postal Code

HOME PHONE _____ **BUSINESS** _____
OTHER _____

E-mail address _____

DATE OF BIRTH _____ **MALE/FEMALE** _____

DENTAL INSURANCE YES NO

NAME OF COMPANY _____

PERSON RESPONSIBLE FOR ACCOUNT: SAME AS ABOVE or _____

MEDICAL HISTORY

Date of last medical examination _____

Name of Medical Doctor: _____ Phone: _____

Is your physician treating you now? YES NO
If so why? _____

Do you have any allergies? i.e. Penicillin/Latex/Foods? YES NO
To what: _____

Ladies: Are you pregnant? YES NO Due Date: _____

Have you had a hip or joint replacement? YES NO

Do you smoke? YES NO
If so how much? _____

Is there anything else we should know about your medical history? YES NO
If so, what? _____

DENTAL HISTORY

1. Are you having any discomfort at this time? YES NO
Please Specify _____
2. Have you been under regular care by a dentist? YES NO
3. Previous Dentist? _____ Last Visit _____
4. What was done at that time? _____
5. Do your gums feel tender or swollen? YES NO
6. Are you aware of any lump or swelling in your mouth? YES NO
7. Do you wish to keep your natural teeth? YES NO
8. Have you ever had a problem with local and general anaesthetic? YES NO
9. Are you tense during dental visits? YES NO
10. Would you be interested in improving the appearance of your teeth? YES NO
11. Describe what you would like done with your teeth _____

12. Do you currently experience? (Please check)
 loose teeth bleeding gums sore gums bad breath
 sensitive teeth popping/clicking jaw earache neck pain
 headache unexplained nose bleeds missing teeth gagging
 spaced or crooked teeth unsatisfactory dentures

GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding this medical-dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services to me or my dependents.

PATIENT SIGNATURE _____

DENT/HYG SIGNATURE _____

If parent, guardian please print name _____

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MEDICAL UPDATES FOR FUTURE DENTAL APPOINTMENTS

Please list any changes in your medical history, any changes in medication or new medications or hospitalizations since your last visit.

DATE: _____ PATIENT SIGNATURE: _____

DENT/HYG SIGNATURE _____

DATE: _____ PATIENT SIGNATURE: _____

DENT/HYG SIGNATURE _____

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DENT/HYG SIGNATURE _____

DATE: _____ PATIENT SIGNATURE: _____

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