WELCOME TO OUR OFFICE

Adult ☐
Child ☐

Name: ____
Last First Initial

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Date of Birth ____________________ Age _____ Marital Status: ________________
D/M/Y

Telephone: _________________________________ | _________________________ | ________________________
Home Work Cell

Mailing Address: ____
Postal code

EmailAddress: ____ Family Physician: ___________________________

Occupation ____________________________ Employer ______________________ Tel: _________________ Ext: ______

Spouse employed by: ____ Tel: _________________ Ext: ______

If a Child (Parent/Guardian's name) ______________________________ Contact Ph. # (if different) __________________

In the case of an Emergency: Notify ________________________ Relationship ________________ Tel: ________________

Is there any other member of your family a patient at our office? Yes ☐ No ☐ If so, who? _________________________

Who referred you to this office? ____

Dental Insurance/Financial Information

Person responsible for account: Self ☐ Spouse ☐ Guardian ☐ Social Assistance ☐ Treaty ☐ Father ☐ Mother ☐

Sask. Health No. ______________________
10 Digit Treaty No. ______________________

How will you be paying for today's treatment? Debit MasterCard VISA Cash

DENTAL INSURANCE NONE ☐ ONE ☐ TWO ☐ or MORE ☐

PRIMARY		**SECONDARY**	
NAME OF SUBSCRIBER	DATE OF BIRTH D /M /Y	NAME OF SUBSCRIBER	DATE OF BIRTH D /M /Y
EMPLOYER/GROUP POLICY HOLDER		EMPLOYER/GROUP POLICY HOLDER	
INSURANCE COMPANY		INSURANCE COMPANY	
GROUP/POLICY NUMBER	DIVISION	GROUP/POLICY NUMBER	DIVISION
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER	I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER

PLEASE NOTE: Missing or Cancelling multiple appointments without adequate prior notice will compromise your standing in the clinic.

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment.
ALL INFORMATION IS CONFIDENTIAL

Question	Yes	Don't Know /Maybe	No
1. Have you ever had a serious illness requiring hospitalization or extensive medical care?................... Specify: ____	☐		☐
2. Are you presently being treated for any conditions?.................... If so, explain: ____	☐		☐
3. Have you had a medical examination in the last year?....................	☐		☐
4. Do you use any prescription or non-prescription medicine regularly?.................... Specify: ____	☐		☐
5. Do you have any allergic condition: i.e. asthma, hay fever, skin rash, food allergies, metal, latex?.......	☐	☐	☐
6. Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea?............. Specify: ____	☐	☐	☐
7. Have you been hospitalized in the last 5 years?....................	☐	☐	☐
8. Have you ever experienced any unusual reaction to any of the following? (please circle) .... Local anaesthesia (freezing), aspirin, penicillin, codeine, sulfonamide, barbiturates (sleeping pills), or any other medicines? If so, explain: ____	☐	☐	☐
9. Have you been warned against taking any drug or medication?....................	☐		☐
10. Do you have or have you had any of the following? (Please check (✓)	☐	☐	☐

☐ Heart murmur or mitral valve prolapse	☐ Malignant hyperthermia	☐ AIDS	☐ Hepatitis ___ (please specify)	☐ Liver disease
☐ Stomach/intestinal problems	☐ Drug/alcohol addiction	☐ Positive testing for HIV Virus	☐ Herpes	☐ Cortisone/steroid therapy
☐ Joint replacement (hip, knee, etc.)	☐ Venereal Disease	☐ Heart attack	☐ Mental or nervous disorder	☐ Any lung disease
☐ Jaundice	☐ Cold sores	☐ High blood pressure	☐ Low blood pressure	☐ Tuberculosis
☐ Thyroid disease	☐ Cancer	☐ Hyper (hypo) glycemia	☐ Arthritis or rheumatism	☐ Sinus trouble
☐ Diabetes	☐ Epilepsy or seizures	☐ Scarlet or rheumatic fever	☐ Stroke	
☐ Kidney disease	☐ Premed required prior to dental treatment			
☐ Other				

Question	Yes	Don't Know /Maybe	No
11. Do you bruise easily or bleed abnormally?....................	☐	☐	☐
12. Have you ever had any injury, surgery or x-ray therapy to your face or jaws?....................	☐	☐	☐
13. Do you have frequent severe headaches?....................	☐	☐	☐
14. Have you ever fainted?....................	☐	☐	☐
15. Have you had any organ transplants or medical implants?....................	☐	☐	☐
16. Do you have any disease, condition or problem that you think the doctor should know about?..........	☐	☐	☐

DENTAL HISTORY

1. How often do you brush your teeth? ______________________ 2. How often do you floss your teeth? ________________

INFORMED CONCENT / 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 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.

Patient (Parent, Guardian) Signature: ____

If parent, guardian*, please print name: ______________________________ Date ____________
M D Y

STC HEALTH BUS INFORMED CONSENT

I, ____________________________, give my consent for my son/daughter/grandchild
(Parent/ Guardian)
to be seen by the dental team on the STC Health Bus.

- I am aware that he/she will have an examination and any necessary x-rays, as well as the possibility of a dental cleaning on the initial visit.

- I will be presented with a treatment plan and made aware of any upcoming appointments.

- I will be given the opportunity to ask any questions I have regarding the Necessary treatment

Date: ________________________

Child's Name: ____

I understand that by signing, I am confirming that I am the legal guardian/parent of the named child above and will continue involvement in my child /grandchild's oral health.

Parent/Guardian: ____