Personal Information

Name: _____
Address: _____
_____
City: _____ Postal Code: _____
Res. Phone: _____
Work Phone: _____
Cell Phone: _____
Employed by: _____
Spouse Name: _____
Spouse Employed by: _____
_____

Wish to be called: _____
Parent/Guardian: _____
Birth date: _____
Email: _____
Marital Status: _____
Person Responsible for account: _____
Whom may we thank for referring you?
_____
_____
_____
_____

❑O ❑S **DENTAL INSURANCE** ❑B ❑T

Person Insured: _____ B. Date: _____
Employer: _____
Ins. Co.: _____
Coverage: _____ A _____ B _____ C _____ D
Deduct: Limit:
GP#: _____ Dep: _____ Acct: _____
Sin#: _____ Cert#: _____ Div: _____
Mail to: _____
_____
_____

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Brian E. Standerwick and authorize payment directly to him.

_____
Signature of subscriber Date

❑O ❑S **DENTAL INSURANCE** ❑B ❑T

Person Insured: _____ B. Date: _____
Employer: _____
Ins. Co.: _____
Coverage: _____ A _____ B _____ C _____ D
Deduct: Limit:
GP#: _____ Dep: _____ Acct: _____
Sin#: _____ Cert#: _____ Div: _____
Mail to: _____
_____
_____

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Brian E. Standerwick and authorize payment directly to him.

_____
Signature of subscriber Date

Medical Alert: _____
Physician's Name: _____
Phone: _____
Specialist Name: _____
Phone: _____
Premedication: _____
Rx: _____
Pharmacy Name: _____
Phone: _____
Current Medications: _____
_____
_____

MEDICAL HISTORY

1) Are you under physician's care at present? Yes ❑ No ❑
   If yes, for what reason? _____
2) Have you been hospitalized? Yes ❑ No ❑
   When? _____
3) Have you been seriously ill? Yes ❑ No ❑
   When? _____
4) Have you had major surgery? Yes ❑ No ❑
   Blood transfusion? Yes ❑ No ❑
5) Do you have or have you had?

- ❑ congenital hearth disease
- ❑ heart murmur
- ❑ artificial heart valve/pacemaker
- ❑ heart disease or attack
- ❑ high blood pressure
- ❑ artificial joints
- ❑ chest pains/angina
- ❑ rheumetic fever
- ❑ stroke
- ❑ hemophilia/bleeding disorders
- ❑ anemia
- ❑ asthma
- ❑ shortness of breath
- ❑ congestive heart failure
- ❑ emphysema
- ❑ tuberculosis (TB)
- ❑ sinusitis
- ❑ arthritis
- ❑ rheumatism
- ❑ radiation and/or
- ❑ chemotherapy
- ❑ seizures, convulsions
- ❑ or epilepsy
- ❑ diabetes
- ❑ yellow jaundice or
- ❑ liver disease
- ❑ thyroid disease
- ❑ ulcer
- ❑ kidney disease
- ❑ venereal disease
- ❑ infectious or
- ❑ communicable disease
- ❑ drug addiction
- ❑ hepatitis A or B or C

6) Are there diseases or medical problems that run in your family? Yes ❑ No ❑
   _____
7) Have you any allergies? Yes ❑ No ❑
   If yes, please name the substance or drugs to which you are allergic _____
8) Have you ever had peculiar reaction to general anaesthetics, medicines or injections? Yes ❑ No ❑
   (e.g. freezing, penicillin?) _____
9) Are you presently taking medicines or non-prescription drugs of any kind? Yes ❑ No ❑
   If yes, please name these drugs, their dosage and frequency _____
10) Do you smoke? Yes ❑ No ❑
    How much? _____
11) Have you ever tested positive for
    Hepatitis A B or C virus? Yes ❑ No ❑
    HIV virus (A.I.D.S.)? Yes ❑ No ❑
12) Are you in a high risk group for either of the above viruses? Yes ❑ No ❑
13) Are you on a special diet? Yes ❑ No ❑
14) Have you any other medical conditions that are important for our dental team to know about? Yes ❑ No ❑
    _____
15) For women: Are you pregnant? Yes ❑ No ❑
    How many months? _____

DENTAL HISTORY

1) Previous Dentist: _____
2) Date of last dental visit: _____
   last set of full-mouth x-rays _____
   last panorex x-ray _____
   last complete dental exam _____
3) Do you presently wear:
   a complete denture? Yes ❑ No ❑
   a removable partial denture? Yes ❑ No ❑
   If yes, please identify:
   where they were made _____
   when they were made _____
   last relined? _____
4) What is your immediate dental concern? _____
   _____
5) How often do you brush your teeth? _____
6) What type of brush do you use (e.g. soft, medium or hard)?
   _____
7) What type of toothpaste do you use?
   _____
8) Do you use dental floss? Yes ❑ No ❑
   How often? _____
9) Are you taking flouride supplements? Yes ❑ No ❑
   If yes, what type? _____

Please answer yes or no to the following:

1) Have you had oral hygiene instruction before? Yes ❑ No ❑
2) Do your gums often bleed when you brush your teeth? Yes ❑ No ❑
3) Have you lost any teeth? Yes ❑ No ❑
   from what cause? _____
4) Have you ever had orthodontic treatment? Yes ❑ No ❑
   When? _____
5) Have you ever had periodontal treatment? Yes ❑ No ❑
   When? _____
6) Do you have a burning sensation in your mouth? Yes ❑ No ❑
   If yes, when? _____
7) Do you catch food between your teeth? Yes ❑ No ❑
8) Are you aware of your jaw clicking or popping while eating or yawning? Yes ❑ No ❑
9) Are you aware that you grind or clench your teeth? Yes ❑ No ❑
   If yes, when? _____
10) Do you have an unpleasant taste or odour in your mouth? Yes ❑ No ❑
    _____
11) Do you want to learn to control your dental disease and retain your teeth? Yes ❑ No ❑
12) Are you pleased with the appearance of your teeth? Yes ❑ No ❑
13) Have you ever had an upsetting experience in a dental office? Yes ❑ No ❑

_____
_____
_____

Signature or (parent/guardian) **Date**