## Welcome to Danube Dental Clinic

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you.  $Please\ Print$ .

Name: First	Initial		Last		
Address:Street	Apt.	City	Prov.	Postal Code	
Date of Birth / /	Home Tel.( )				
			Tel.( )		
Referring Person:					
Financial Information:					
Method of payment: Cash	Cheque	Credit Card	Insurance Oti	ner	
Person Responsible for fina	ancial matters: Self	Spouse F	Parent/Guardian	Other	
Primary Insurance:			· · · · · · · · · · · · · · · · · · ·		
Ins.Company					
Employer/Policy Holder					
Policy/Group #		Certific	cate #		
			^		
Secondary Insurance					
Ins. Company					
Employer/Policy Holder			·		
Policy#		Certificate#			
		General Consent	Statement		
and have not knowingly omit and to receive answers regal egarding any specific medic general or local anesthetic, a equired, to achieve the prop provided even if my insurance	ted any information. This in rding any medical and dentical question. I authorize the as required, to achieve the der level of dental care. I under coverage may not be all i	information has been all histories. As more dentist to performation procedured and erstand that I an inclusive. I know the stand the sta	en reviewed with me, ar ay be required, I consent a necessary diagnostic pures and treatment, include an financially responsible that your office has a pri	histories, to the best of my knowledge, and I have had the chance to ask question it to my physician being contacted procedures and treatment, including uding general or local anesthetic, as to the dentist for the dental services wacy code, and I can ask to see the codes set out in your office privacy policy.	
Signature: SelfParent/Gua	ardian Print Name			3	

	al History  Date					
(1111511	nformation will remain confidential)	.,				
1. A	re you presently under the care of a physician? If so, explain	Yes	No			
2. H	ave you ever been hospitalized? Explaine you taking any drugs or medication at this time?					
3. Ar	e you taking any drugs or medication at this time?		1			
ω).	b)					
e)_	a)Reason					
4 Ha	T) Doggen					
As	ave you ever had any adverse effect to any of the following: Antibiotics – PenicillinSulphonamideOther pirin, Barbiturates (sleeping pills), Codeine, Darvaon, Local Anaesthetic, None					
5. Ha	Have you ever taken prolonged medical or non-medical drugs?					
6. Ha	Have you ever taken prolonged medical or non-medical drugs?					
8. Do	you have or have you ever had: a) Any heart or blood pressure problems?					
	D) A neart murmur or mitral valve problem?					
0 0						
9. Do						
10. 00	you bruise easily or have prolonged pleeging?					
11. 00	you smoke? How much per day?					
13. Are						
	e you pregnant? Yes No Using birth control? Yes No Reached menopause Yes No you have or have you ever had any of the following?					
14. DC	you have or have you ever had any or the following?	None				
A.I	.D.S.   Cortisone/steroid High/low Blood pressure Psychiatric disorder					
Ana	Aemia Diabetes H.I.V. Positive Psychiatric disorder					
Ang	gina pectoris Drug/Alcohol Dependence Hodgkin's disease Rheumatic/Scarlet f					
	prexia nervosa	CVCI				
_	ficial heart Valve					
	pritis/rheumatism Glandular disorders Jaundice Stomach/intestinal p	roblems				
	ficial joints (hip/knee) Glaucoma Kidney disease Stroke					
	and disease Triyroid disease					
	nochific Tuberculosis					
Buli						
Can						
Circu	ulation problems Hepatitis A/B/C Mitral valve prolapse Other					
Cong	genital heart lesions Herpes Organ transplant/implant Other					
Dental H						
1.	What is the reason for today's visit?					
2. 3.	How frequently do you see a dentist: 3-6 months Annually Other					
3. 4.	When was your last dental visit? Last x-rays?					
5.	How often do you brush per day?FlossUse anti-bacterial rinse? Are your teeth sensitive to: Sweet Heat Cold					
6.						
7.	Do your gums feel swallen or tandor?	Yes	No			
8.	Do you have bad breath or a bad taste in your mouth?					
9.	Do your laws crack or non when you onen widely?					
10.	Do you grind or clench your teeth?					
11.	Do you grind or clench your teeth?  Do you have food traps between your teeth?					
12.	20 you have look hape between your teeth:					
	<ul><li>12. Have you ever had any complication with local anaesthetic (freezing)?</li><li>13. Have you ever had any problems with previous dental treatment? Specify</li></ul>					
14	Have you ever had any problems with previous definal treatment? Specify		-			
	Orthodontic (braces) Periodontal (gums) Root canal					
15	Are you satisfied with your teeth? Specify					