

1. PERSONAL INFORMATION

Last Name	First Name	Middle / Preferred Name
Mailing Address	City, Province	Postal Code
Date of Birth (dd / mm / yyyy)	Gender ☐ Male ☐ Female ☐ Other	
Home Phone	Cell Phone	Email
Employer	Occupation	
Emergency Contact	Relationship	Phone
Other family members under our care		Preferred method of contact ☐ Text ☐ Email ☐ Phone
How did you hear about us? ☐ Google ☐ Friend / Family ☐ Social Media ☐ Other		If referred, by whom?

2. INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE (IF APPLICABLE)	
Insurance company name	Policy / Group number	Insurance company name	Policy / Group number
Contract / ID number	Subscriber name	Contract / ID number	Subscriber name
Subscriber date of birth	Relationship to subscriber	Subscriber date of birth	Relationship to subscriber

3. COVERAGE SUMMARY

Yearly Maximum \$ _____	Basic Coverage _____ %	Major Coverage _____ %
Deductible \$ _____	Renewal on calendar or rolling year _____	Recall frequency _____

4. DENTAL HISTORY

How would you rate the current condition of your mouth?

☐ Excellent
 ☐ Good
 ☐ Fair
 ☐ Poor

Previous dentist or dental office	How long a patient?	Most recent exam	Most recent x-rays
Most recent dental treatment		I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely	

JAW & BITE

Do you grind or clench your teeth? ☐ Yes ☐ No
 Do you have jaw discomfort, clicking, popping, locking, or limited opening? ☐ Yes ☐ No
 Do you have difficulty chewing firm or sticky foods? ☐ Yes ☐ No
 Does your bite feel uneven or uncomfortable? ☐ Yes ☐ No

DENTAL ANXIETY

Are you fearful or anxious about dental treatment? ☐ Yes ☐ No
 Have you ever delayed dental care because of anxiety? ☐ Yes ☐ No
 Have you had a difficult dental experience in the past? ☐ Yes ☐ No
 Would you like us to discuss ways to make your visit easier? ☐ Yes ☐ No

SMILE APPEARANCE

Is there anything about the appearance of your teeth you would like to change? ☐ Yes ☐ No
 Are you self-conscious about your teeth? ☐ Yes ☐ No
 Have you ever whitened or bleached your teeth? ☐ Yes ☐ No
 Have you been disappointed with previous cosmetic dental work? ☐ Yes ☐ No

TEETH & GUMS

Have you had any cavities in the past five years? ☐ Yes ☐ No
 Are any teeth sensitive to hot, cold, biting, or sweets? ☐ Yes ☐ No
 Do your gums bleed when brushing or flossing? ☐ Yes ☐ No
 Do you have a dry mouth? ☐ Yes ☐ No
 Have you had a broken, chipped, or cracked tooth or filling? ☐ Yes ☐ No
 Have you ever had periodontal (gum) treatment? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Is there anything else you would like our dental team to know before your appointment?

1. PATIENT & PHYSICIAN INFORMATION

Patient Name	Patient ID # (office use)
Family Doctor / Physician and Specialty	Pharmacy Name
Permission to contact pharmacy ☐ Yes ☐ No	

Please list all prescription and non-prescription medications you are currently taking:

Medication(s)

If you are unsure of the effect of any medication you are taking or any medical condition you have, please discuss it with your dentist or dental hygienist before treatment.

2. WOMEN PATIENTS ONLY

	YES	NO
Are you pregnant? If yes, how far along are you? _____	☐	☐
Are you nursing?	☐	☐

3. PERSONAL HISTORY

	YES	NO
Have you ever had major surgery? If yes, what type? _____	☐	☐
Has a medical doctor advised that you need pre-medication before dental treatment? _____	☐	☐
Have you ever had a mouth or jaw injury? _____	☐	☐
Have you ever taken medication for osteoporosis (Fosamax, Zometa, Aredia, or others)? _____	☐	☐
Do you smoke or vape? If yes, how often and for how many years? _____	☐	☐
Have you consumed alcohol, cannabis, or illegal drugs, specifically cocaine, in the last 48 hours? *	☐	☐

*This information is confidential. Excessive amounts of alcohol or drugs in your system during dental treatment can seriously affect your heart.

4. ALLERGIES & MEDICAL CONDITIONS

Please check any condition you have experienced:

☐ Allergy – Clindamycin	☐ Atrial Fibrillation	☐ Heart Stent(s)	☐ Radiation Treatment
☐ Allergy – Codeine	☐ Blood Disorders	☐ Heart Surgery	☐ Respiratory Problems
☐ Allergy – Ibuprofen	☐ Cancer	☐ Hepatitis A	☐ Rheumatoid Arthritis
☐ Allergy – Latex	☐ Dementia	☐ Hepatitis B	☐ Scarlet Fever
☐ Allergy – Local Anesthetic	☐ Diabetes	☐ Hepatitis C	☐ Smoking
☐ Allergy – Penicillin	☐ Dizziness / Fainting	☐ High Blood Pressure	☐ Sinus Trouble
☐ Allergy – Metals	☐ Epilepsy	☐ Kidney Disease	☐ Sleep Apnea
☐ Anemia	☐ Excessive Bleeding	☐ Liver Disease	☐ Stomach Problems
☐ Anxiety	☐ Gastro-Intestinal	☐ Low Blood Pressure	☐ Stroke
☐ Arthritis	☐ HIV+ (AIDS)	☐ Malignant Hyperthermia	☐ Thyroid – Hyper / Hypo
☐ Artificial Heart Valve	☐ Head & Neck Injury	☐ Mitral Valve Prolapse	☐ TMJ
☐ Artificial Joints	☐ Hearing Disabled	☐ Multiple Sclerosis	☐ Vertigo
☐ Angina	☐ Heart Attack	☐ Osteoporosis	☐ Von Willebrand Disease
☐ Asthma	☐ Heart Disease	☐ Pacemaker	

Do you have any other health issues or allergies?

Please describe

5. PATIENT CERTIFICATION & CONSENT

I certify that I have read, understood, and accurately completed the personal, medical, and dental histories to the best of my knowledge. As may be required, I consent to my physician being contacted regarding any specific medical questions. I authorize Dr. Luke Singh and Associates to perform necessary diagnostic procedures and treatment. I understand that I am financially responsible for the dental services provided, even if my insurance coverage may not be all-inclusive.

Patient / Guardian Signature	Date (dd / mm / yyyy)
Printed Name	Relationship to Patient (if applicable)