

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best dental care. To help us meet all of your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Dr. Judy N. Sturm

Patient Information (Confidential)

Name _____ Birth date _____ Date _____
Home Phone _____
Address _____ City _____ P Code _____
Check Appropriate Box: Single Married Divorced Widowed Other Birthplace _____
Employer _____ Occupation _____ Work Phone _____
Whom may we thank for referring you? _____
Person to Contact in Case of Emergency _____ Relationship _____

Responsible Party

Name of Person Responsible for this account _____ Relationship _____
Address _____ Home Phone _____
Employer _____ Work Phone _____
Is This Person Currently A Patient in our Office Yes No

Insurance Information

Name of Insured _____ Birthdate _____
Relationship to patient _____ S.I.N. _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ Province _____ P Code _____
Insurance Company _____ Certificate# _____ Group# _____

Do You Have Any Additional Insurance? Yes No If yes, complete the following:

Name of Insured _____ Birthdate _____
Relationship to patient _____ S.I.N. _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ Province _____ P Code _____
Insurance Company _____ Certificate# _____ Group# _____

Patient Medical History

Physician _____ Office Phone _____ Date of last exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	6. Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you in general good health at this time?...	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalized for any surgical operations or any illnesses?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking any medication (s) including non-prescription medicine?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you smoke or chew tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
			Other.....	<input type="checkbox"/>	<input type="checkbox"/>
			7. Women only:		
			a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have or have you had any of the following?			b) Are you taking birth control pills?.....	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No		Yes	No		Yes	No
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac pacemaker..	<input type="checkbox"/>	<input type="checkbox"/>	Stomach troubles/ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains/Angina..	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/convulsion.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problem	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight loss.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement or implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	6. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you had any orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever experienced any of the following in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have you ever had instruction on the correct method of brushing your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
a) Clicking	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever had instructions on the care of your gums?	<input type="checkbox"/>	<input type="checkbox"/>
b) Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you unhappy with the appearance of your smile?	<input type="checkbox"/>	<input type="checkbox"/>
c) Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>	12. Are you satisfied with the colour of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
d) Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you feel that you may have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>			

14. Please tell us any concerns you have about your teeth _____

15. Name of Previous Dentist _____ Date of Last Visit _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners which may be submitted electronically. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor _____