THANK YOU FOR SELECTING OUR DENTAL HEALTHCARE TEAM! WE WILL STRIVE TO PROVIDE YOU WITH THE BEST DENTAL CARE. TO HELP US MEET ALL 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 STURM & ASSOCIATES

Physician_____ Office Phone_____Date of last Exam_____

Medical History

	Yes	No
Are you under medical treatment now?	☐	☐
Are you in general good health at this time?	☐	☐
Have you ever been hospitalized for any surgical operations or any illness	☐	☐
_____		
Are you taking any medications; Please list:		
_____	☐	☐
_____		
Do you require premedication? If yes, explain	☐	☐
_____		
Do you smoke or chew tobacco?	☐	☐
Do you smoke/consume marijuana?	☐	☐
Are you tired during the day?	☐	☐
Have you ever been told you might have sleep apnea?	☐	☐
Have you been told to wear a CPAP/ wear a CPAP?	☐	☐
Have you been told that you snore/do you snore?	☐	☐

	Yes	No
Are you allergic to or had any reactions to the following:		
Local Anesthetics (i.e. lidocaine)_____	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Aspirin	☐	☐
Metals	☐	☐
Latex	☐	☐
Other	☐	☐
_____		
Are you pregnant or think you may be pregnant? (Women only)	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Do you have or have you had any of the following medical conditions listed below:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Murmur	☐	☐	Hepatitis/Jaundice	☐	☐
Low Blood Pressure	☐	☐	Heart Attack	☐	☐	Liver Disease	☐	☐
Heart Disease	☐	☐	Cardiac Pacemaker	☐	☐	Sexually Transmitted disease	☐	☐
Rheumatic Fever	☐	☐	Chest Pains/Angina	☐	☐	Stomach Troubles/Ulcer	☐	☐
Asthma	☐	☐	Respiratory Problems	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Stroke	☐	☐	Tuberculosis	☐	☐
Epilepsy/Convulsions	☐	☐	Emphysema	☐	☐	Radiation/Chemo Therapy	☐	☐
Leukemia	☐	☐	Anemia	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Abnormal Bleeding	☐	☐	Osteoporosis	☐	☐
Kidney Disease	☐	☐	Arthritis	☐	☐	Recent Weight Loss	☐	☐
AIDS or HIV infection	☐	☐	Glaucoma	☐	☐	Sinus Problems	☐	☐
Drug / Alcohol Abuse	☐	☐	Joint Replacement	☐	☐	Severe/Frequent Headaches	☐	☐

Other_____

Authorization and Release

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information. 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/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 dependants. I am aware that 2 business days notice is required to change or reschedule an appointment with no charge.

Signature of patient or parent if minor_____Date_____

77 Bloor Street West, Suite 1202
416-967-422
yorkvillesmiles.com

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DR. JUDY STURM & ASSOCIATES

☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐Dr.

Name: _____ Date of Birth: DD / MM / YYYY

Address: _____ City: _____ Postal Code: _____

Home phone:( ) _____ Work phone: ( ) _____ Cell phone: ( )_____

E-mail address: _____

Preferred contact? ☐Home ☐Cell ☐Work ☐Email

Employer_____ Occupation_____

Who may we thank for the referral? _____ ☐Website ☐Google ☐Other

Emergency Contact: _____ Relation: _____ Phone:( )_____

INSURANCE INFORMATION

Name of Insured_____ Birthdate_____

Relationship to patient_____ Name of Employer_____

Insurance Company_____ Certificate #_____ Group #_____

SECONDARY INSURANCE (if applicable)

Name of Insured_____ Birthdate_____

Relationship to patient_____ Name of Employer_____

Insurance Company_____ Certificate #_____ Group #_____

DENTAL HISTORY

What are your present dental concerns, if any?

☐ Bleeding Gums ☐ Crooked Teeth ☐ Cosmetic ☐ Loose teeth ☐ Bad Breath

☐ Food trapping ☐ Sensitive Teeth ☐ Toothache ☐ Loose Denture ☐ Missing teeth

Have you experienced any of the following in your jaw?

☐ Clicking ☐ Pain ☐ Difficulty in chewing ☐ Difficulty in opening or closing ☐ Earaches

	Yes	No
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you presently wear a nightguard?	☐	☐
Have you had any orthodontic work?	☐	☐
Have you ever had prolonged bleeding after extractions?	☐	☐
Do you regularly have dental cleanings done?	☐	☐
Do you like your smile?	☐	☐

If No, please explain what you would like to change

_____

Are you satisfied with the colour of your teeth?	☐	☐
Have you had a bad experience in the dental Office?	☐	☐

Please explain

_____

What is the reason for today's visit_____

_____

Name of previous dentist_____ Date of last Visit_____

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