



Chow

DENTAL GROUP

Dr. David Chow, DDS

1 Hallstone Road, Brampton, ON L6Y 0S9

905-455-1231 • www.chowdentalgroup.com

PATIENT INFORMATION

Welcome to Our Dental Office!

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the entire form.

PERSONAL INFORMATION

Dr. Mr. Mrs. Miss Ms

First Name: _____

Status: Single Married Child Other

Home Address: _____

City: _____

Email: _____

Work Tel: _____

Employer: _____

Physician: _____

Previous Dentist: _____

Why have you decided to change dental offices? _____

How did you hear about us? _____

Last Name: _____

Mid: _____ Preferred Name: _____

Date of Birth (DD/MM/YY): _____ / _____ / _____

Apt: _____

Postal Code: _____

Home Tel: _____

Cell: _____

Occupation: _____

Physicians Phone No: _____

INSURANCE INFORMATION 1

Name of insured if different from above: _____

Employer: _____

Insurance Company: _____

Division (If applicable): _____

Do you have Secondary Insurance? No Yes

Date of Birth of Insured (DD/MM/YY): _____ / _____ / _____

Policy/Group: _____

Certificate ID#: _____

(Please fill out the next section)

INSURANCE INFORMATION 2

Name of insured if different from above: _____

Employer: _____

Insurance Company: _____

Division (If applicable): _____

Date of Birth of Insured (DD/MM/YY): _____ / _____ / _____

Policy/Group: _____

Certificate ID#: _____

EMERGENCY CONTACT

Relationship: _____

Name: _____

Tel: _____

MEDICAL HISTORY

YES NO

Are you being treated for any medical condition at the present or have you been treated within the last year? YES NO

If yes, specify: _____

When was your last medical check-up? _____

Has there been any change in your general health in the past year? YES NO

Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below: YES NO

Drug: _____

Reason: _____

Drug: _____

Reason: _____

Drug: _____

Reason: _____

Drug: _____

Reason: _____

SEE REVERSE ➔

YES NO

Do you have any allergies? Latex Other: _____ YES NO

Have you had an unusual reaction to any drugs or medicines? YES NO

Penicillin Sulfonamide Aspirin Codeine Local Anesthetic Other: _____

Have you ever taken cortisone or steroid medication? YES NO

Do you have any sinus problems? YES NO

Do you have or have you ever had any heart problems? YES NO

Do you have a pacemaker? YES NO

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? YES NO

Do you or have you ever had jaundice, hepatitis or liver disease? YES NO

Do you have a bleeding problem or bruise easily? Are you on blood thinner? YES NO

Do you have any conditions that could affect your immune system ego AIDS, HIV infection, Leukemia etc? YES NO

Do you smoke? If yes, how much? _____ YES NO

Have you ever been hospitalized for any serious illnesses or operations? YES NO

Do you have any prosthetic or artificial joints? YES NO

Do you have or have you ever had any of the following?

<input type="checkbox"/> Chest Pain/Angina	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Asthma
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemotherapy/Radiation
<input type="checkbox"/> Psychiatric Disorder	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Drug/Alcohol Dependency		

For females: Are you pregnant or breast feeding? YES NO

Any other conditions or problems of which the dentist should be aware of? YES NO

If yes, please list: _____

DENTAL HISTORY

When was your last dental visit? _____

When did you last have dental x-rays? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Have you been seeing a dentist regularly? YES NO

Do any of your teeth ache? YES NO

Have you ever been advised to take antibiotics before dental appointments? YES NO

Do your gums bleed when you brush? YES NO

Do you have any pain when you chew? YES NO

Do you feel that you have bad breath? YES NO

Have you ever been in a motor vehicle accident or experienced any blows to your jaw? YES NO

Have you ever had a dental implant surgery? YES NO

If yes, who performed the surgery and when was it done? _____

Are you being followed-up by a dental specialist? YES NO

Please list anything else not mentioned above regarding your past dental history: _____

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge, and not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

Signature of Patient

DD/MM/YYYY

Reviewed by Dentist

DD/MM/YYYY