



**Patient Name**

First: \_\_\_\_\_ Last: \_\_\_\_\_ MI: \_\_\_\_\_

**Gender**

Male  Female

**Family Status**

Married  Single  Child  Other

**Birth Date**

Date: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

**Phone**

Home: \_\_\_\_\_

Mobile: \_\_\_\_\_

**Email**

\_\_\_\_\_

**Address**

\_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

**How did you hear about Sana Dentistry?**

Friends / Family  Google  Facebook  Instagram  
 Walk-in  Yelp  Opencare  Prep Doctors  
 Newsletter  Other \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Family Doctor ( Optional )**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**Referring Doctor ( Optional )**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_



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. If you do not understand any of the questions, please ask and we would be happy to explain. Please fill in the entire form.

**Are you being treated for any medical condition at the present or have you been treated within the past year?**

Yes       No

If yes, what condition?

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**When was your last dental visit?**

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**Has there been any change in your general health in the past year?**

Yes       No

If yes, please explain.

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**Are you taking any medication, non-prescription drugs or herbal supplements of any kind?**

Yes       No

If yes, please explain.

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**Do you smoke or chew tobacco products?**

Yes       No

**Are you nervous during dental treatment?**

Yes       No

**Have you ever had a peculiar or adverse reaction to any medicines or injections?**

Yes       No

If yes, please explain.

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**Do you or have you had any of the following medical conditions**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergy - Aspirin          | <input type="checkbox"/> Allergy - Codeine      | <input type="checkbox"/> Allergy - Iodine    |
| <input type="checkbox"/> Allergy - Latex            | <input type="checkbox"/> Allergy - Penicillin   | <input type="checkbox"/> Allergy - Sulfa     |
| <input type="checkbox"/> Allergy - Erythromycin     | <input type="checkbox"/> Allergy - Local Anesth | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Anaphylaxis                | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Artificial Heart Valve     | <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Blood Disease              | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Chest Pains         |
| <input type="checkbox"/> Circulation Problems       | <input type="checkbox"/> Contraceptive Use      | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Circulation Problems       | <input type="checkbox"/> Dizziness / Fainting   | <input type="checkbox"/> Emphysema           |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Excessive Bleeding     | <input type="checkbox"/> Excessive Bruising  |
| <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Gastro-Intestinal      | <input type="checkbox"/> Glaucoma            |
| <input type="checkbox"/> Hard To Freeze             | <input type="checkbox"/> Hay Fever              | <input type="checkbox"/> HBP                 |
| <input type="checkbox"/> Head Injury                | <input type="checkbox"/> Hearing Disabled       | <input type="checkbox"/> Heart Murmur        |
| <input type="checkbox"/> Heart Pacemaker            | <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Hepatitis A         |
| <input type="checkbox"/> Hepatitis B                | <input type="checkbox"/> Hepatitis C            | <input type="checkbox"/> HIV + (AIDS)        |
| <input type="checkbox"/> Hives                      | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Kidney Disease      |
| <input type="checkbox"/> LBP                        | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Lung Disease        |
| <input type="checkbox"/> Mental Disorders           | <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> Nervous Disorders   |
| <input type="checkbox"/> Organ / Medical Transplant | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems       | <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Rheumatism          |
| <input type="checkbox"/> Rheumatoid Arthritis       | <input type="checkbox"/> Sinus Problems         | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Skin Rash                  | <input type="checkbox"/> STD                    | <input type="checkbox"/> TMJ                 |
| <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Tumors                 | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Wheelchair                 |   |  |

**Are there any conditions or diseases not listed above that you have or have had?**

- Yes       No

If yes, please explain.

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**For women only: Are you breastfeeding or pregnant? What is the expected delivery date?**

- Yes       No

Date

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Please list any prescription or non-prescription medicine you are currently taking or have recently taken.

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Are you allergic to have you had a reaction to any of the following items?

Antibiotics

Aspirin

Codeine

Darvon

Local Anaesthetic

Nitrous Oxide

Other:

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Do you use any form of tobacco or wear a nicotine patch?

Yes

No

Are you dependent on alcohol or drugs?

Yes

No

If so, have you received treatment?

Yes

No

Have you ever tested HIV positive?

Yes

No

If you have ever been advised against taking any type of medication, please list them below.

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If you have any allergic conditions please list them below. This can include asthma, hay fever, food allergies, and metal or latex allergies.

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Do you bruise easily or bleed severely when you are cut?

Yes

No

Do you have severe earaches, ear or throat infections, or headaches?

Yes

No

Do you wear eyeglasses or contact lenses?

Yes

No



**Cancellation Policy**

Please know that appointment times have been reserved especially for you, and any change in the schedule affects many people. **If for any reason you are unable to keep the reserved appointment time, we ask the courtesy of two business days' notice to allow us to offer the time to another client who may be waiting for an opening.** Appointments cancelled with less than two business days' notice may be subject to a broken appointment fee, the amount of the fees is dependent on the type of the appointment. \_\_\_\_\_ (Please initial)

**To the best of my knowledge, the above information is correct.**

**Patient / Parent / Guardian:**

\_\_\_\_\_

**Doctor's Signature:**

\_\_\_\_\_

**Signature:**

\_\_\_\_\_

**Date:**

\_\_\_\_\_