STERLING FAMILY DENTISTRY

Dr. J.S. Mann, DMD

#1-6305 Scott Road, Delta, BC V6E 4A2
T: (604) 590-9310 F: (604) 590-9319
Email: info@sterlingfamilydentistry.ca
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Thank you for visiting Sterling Family Dentistry.
We want your visit to be a pleasant and comfortable experience. Please help us by completing this form.

Section I **Patient Information** **Date:** _____

Last name: _____ First Name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone: Home (____) _____ Mobile (____) _____ Work (____) _____

Date of Birth: (YY/MM/DD) _____ Gender: ○ Male ○ Female

Marital Status: ○ Minor ○ Single ○ Married ○ Separated ○ Widowed ○ Divorced

E-mail Address: _____ Would you like to receive our e-newsletter? ○ Yes ○ No

Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____

Who may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Are you a student? ○ Yes ○ No If yes, Institution Name: _____

Institution's Address: _____ ○ Part-time ○ Full-time

Section V **Dental History and Your Current Needs**

Why have you come to the dentist today? _____

Do you require antibiotics before Dental Treatment? ○ Yes ○ No Are you currently in pain? ○ Yes ○ No

Have you lost any teeth? ○ Yes ○ No If yes, why? ____

Do your gums ever bleed? ○ Yes ○ No Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ○ Yes ○ No

Do you now or have ever experienced pain or discomfort in your Jaw joint (TMJ/TMD)? ○ Yes ○ No

Are your teeth Sensitive to heat, cold or anything else? ☐ Cold ☐ Hot ☐ Other: _____

Patient Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Payment is due in full at the time of treatment. I understand that I am ultimately responsible for payment of services rendered and that I will be asked to immediately pay that portion of any treatment, including co-payments and deductibles, which my insurance does not cover. I hereby authorize payment directly to Sterling Family Dentistry of the group insurance benefits for all costs of dental treatment and I further authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company in support of any insurance claim, or authorization of treatment relating to any insurance claim.

_____ _____

Signature of Patient, Patient's Parent or Guardian Date

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Section IV **Medical History**

Last Name:_____ First Name:_____ Preferred Name:_____

Are you under physician's care now?	○ Yes ○ No	If yes, please explain:_____
Have you been hospitalized or had a major operation?	○ Yes ○ No	If yes, please explain:_____
Have you had a serious head or neck injury?	○ Yes ○ No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes, please explain:_____
Are you on a special diet?	○ Yes ○ No	If yes, please explain:_____
Do you use tobacco?	○ Yes ○ No	If yes, please explain:_____
Do you use controlled substance?	○ Yes ○ No	If yes, please explain:_____

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other: _____

Do you have, or have you had any of the following:

AIDS/HIV Positive	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Rheumatism	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Dizziness	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Scarlet fever	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Shingles	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Hives or Rashes	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Intestinal Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting	○ Yes ○ No	Leukemia	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Blood Disease	○ Yes ○ No	Fever	○ Yes ○ No	Liver Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Ulcers	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Psychiatric Care	○ Yes ○ No		
Cold Sores	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Radiation Treatments	○ Yes ○ No		
Congenital Heart Disorders	○ Yes ○ No	Heart Pace Maker	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No		
Convulsions	○ Yes ○ No	Heart Disease	○ Yes ○ No	Renal Dialysis	○ Yes ○ No		
Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No		

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the treatment recommendations and costs may change if treatment times are delayed.

_____ _____

Signature of Patient, Patient's Parent or Guardian Date