Welcome to our Office!

Please take a few minutes to provide us with the following important information

Patient name:_____

Home address:_____

City: _____

Prov: _____ Postal Code: _____

Home Phone: _____ Cell Phone:_____

D.O.B: _____ Age:_____ M or F

Dentist: _____

Email Address _____

Dental Information

Please check the box if you have /had one/any of the following:

- ☐ **Clicking jaw**
- ☐ **Locking jaw**
- ☐ **Biting nails**
- ☐ **Thumb/finger sucking**
- ☐ **Accident/Injury to teeth or jaws**

Medical Information

Please check the box if you have/had one/any of the following:

- ☐ **Rheumatic Fever**
- ☐ **Hepatitis/Liver problems**
- ☐ **Bone disorder**
- ☐ **Abnormal bleeding/bleeding disorder**
- ☐ **Diabetes**
- ☐ **Thyroid disorder**
- ☐ **Kidney Problems**
- ☐ **Stomach problems**
- ☐ **Heart conditions**

☐ **Allergies to medications, metals or other. Please specify** _____

☐ **Is there any past or present medical condition not listed above?** _____

☐ **Do you smoke? How much?** _____

☐ **Are you currently taking any prescription medication?** _____

What concerns you about your teeth/smile? (please specify)

_____

_____

How did you find us?
Indicate the top reason for coming here (1) and the other ways you heard about our office (2)

1 or 2 Referred by dentist

1 or 2 Referred by family or friend

1 or 2 Family member was/is being treated by Dr. Bales (name)_____

1 or 2 Recommended by other patient/parents (name)_____

1 or 2 Heard about us through school, community activity, etc

1 or 2 Web site

1 or 2 Team member

1 or 2 Yellow pages or Phone Book

1 or 2 Radio advertisement

1 or 2 Other advertisement _____

Insurance Information

	Self	**Spouse**
Insurance Company:	_____	_____
D.O.B.	_____	_____
Policy or Group #	_____	_____
Certificate or ID #	_____	_____
Employer:	_____	_____

First Canadian Health Benefits Treaty Number: _____