CANYON CREEK DENTAL CLINIC

Medical/Dental History

These questions are of great value in aiding us to better understanding yourself and family.
Please complete all questions on BOTH SIDES of this form.
All answers are kept in strict confidence. Thank – you for your co-operation.

PATIENT'S NAME _____ *Nickname, if any* _____
Age: _____ *BIRTH DATE:* _____ *MALE* _____ *FEMALE* _____

HOME ADDRESS: _____
POSTAL CODE: _____ *TELEPHONE # HOME* _____
CELL # _____ *# WORK* _____
E-MAIL ADDRESS: _____

IN CASE OF AN EMERGENCY WHOM CAN WE CONTACT?
_____ *TELE:* _____

PHYSICIAN'S NAME _____ *TELE:* _____
ALBERTA HEALTH CARE: # _____

PREVIOUS DENTIST: _____ *TELEPHONE #* _____

DENTAL INSURANCE (YOURSELF)
INSURANCE COMPANY NAME:

_____
EMPLOYER NAME:

_____
GROUP/POLICY NUMBER:

_____
EMPLOYEES CERTIFICATE/ID#

_____

DENTAL INSURANCE (SPOUSE)
INSURANCE COMPANY NAME:

_____
EMPLOYER NAME:

_____
GROUP/POLICY NUMBER:

_____
EMPLOYEES CERTIFICATE/ID#

_____

WHOM MAY WE THANK FOR HAVING REFERRED YOU TO OUR OFFICE?
NAME: _____

DENTAL HISTORY

WHAT IS THE REASON FOR THE VISIT? _____

_____

WHEN DID YOU LAST RECEIVE DENTAL TREATMENT? _____

HAVE YOU HAD ANY UNFAVORABLE EXPERIENCES IN A DENTAL OR MEDICAL?
PLEASE DESCRIBE: _____

DID YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING WHICH MIGHT AFFECT YOUR TEETH OR MOUTH:
DENTAL X-RAYS __ BREATHES THROUGH MOUTH __ GUM TREATMENTS __
TEETH EXTRACTIONS __ ROOT CANAL TREATMENT __ BITES FINGERNAILS __
GRINDS TEETH __ HEMORRHAGING __ ORTHODONTIC TREATMENT __ BLEEDING GUMS __
LOOSE TEETH __ UNREPLACED MISSISNG TEETH __