SUNVALLEY
Family Dentistry

NAME:

ADDRESS:

POSTAL CODE:

PHONE: Home Cell

Email

DATE OF BIRTH: M D Y

EMPLOYER: OCCUPATION (optional):

SPOUSE OR PARENTS' NAME (if under 19):

HOW DID YOU HEAR ABOUT US?

EMERG. CONTACT NAME PH:

DENTAL INSURANCE

INS. CO. NAME
* Please give us your dental card!

SUBSCRIBER: BIRTH DATE:

EMPLOYER OF ABOVE:

GROUP NO.: DIV. NO.:

ID NO.:

DENTAL HISTORY

PREVIOUS DENTIST:

DATE LAST SEEN:

REASON FOR CHANGE:

ARE YOU COMFORTABLE WITH DENTISTRY?: Uncomfortable 0 1 2 3 4 5 6 7 8 9 10 Comfortable

IF UNCOMFORTABLE, WHY?:

ANY IMMEDIATE DENTAL CONCERNS?:

MSP NUMBER:

MEDICAL HISTORY

PHYSICIAN: LAST SEEN:

ANY CURRENT MEDICAL PROBLEMS?:

HAVE YOU EVER BEEN HOSPITALIZED?:

REASON:

ARE YOU TAKING ANY MEDICATION, INCLUDING VITAMINS & HERBS?

PLEASE LIST - TAKING FOR:

TAKING FOR:

TAKING FOR:

TAKING FOR:

ANY ALLERGIES? PLEASE LIST:

HAVE YOU EVER HAD?

Rheumatic Fever	Yes	No	Cancer	Yes	No
Heart Condition / Murmur	Yes	No	Hepatitis	Yes	No
Respiratory Disease	Yes	No	High Blood Pressure	Yes	No
Epilepsy	Yes	No	Diabetes	Yes	No
Bleeding Problem / Blood Thinners	Yes	No	Nervous or Mental Disorder	Yes	No
Reaction to Dental Anaesthetic	Yes	No	Thyroid	Yes	No
HIV Positive	Yes	No	Artificial Joints or Dental Implants	Yes	No
Do you Smoke / Tobacco products	Yes	No	Liver / Kidney Condition	Yes	No
# of Years _____ How many per day?_____			Are you Pregnant?	Yes	No

Is there anything else your dentist should be aware of? Yes No

ARE YOU INTERESTED IN

TEETH WHITENING? ❑ Y ❑ N

BOTOX ❑ Y ❑ N

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff, and assume financial responsibility. I also authorize the release of information contained in pre-authorizations and claims submitted electronically and otherwise, and the release of information pertaining to my dental coverage and benefits. The authorization shall continue in effect until the undersigned revokes the same.

Signature: _____ Date: _____