DR. Meera Gopalkrishan
Dental Surgeon

Welcome to Our Dental Office

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ ☐ ADULT ☐ CHILD

Name: ______________ ____________________ _________________ Prefer to be Called: ______________

Address: _____________________ _____________________ ___________________ __________________

Home Phone:_______________________ Work Phone: ____________________ Date of Birth: ___/___/_____

Fax: ______________________________ Other: ____________________________ ☐ Male ☐ Female

Employer/School: ____ Occupation: ______________________

E-mail ID: ______________________ Who may we thank for referring you to this office?: ______________________

Are you likely to be available on short notice for future appointments or appointment changes? ☐ Yes ☐ No

Family Physician: ____ Phone: ________________________

In Case of Emergency Notify: ________________ Relation:______________ Phone: _____________________

Person responsible for this account : ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: ____________

Name: ____ Relation:_________________________

Address: ____

Home Phone: _________________________________ Work Phone: ___________________________________

Primary Insurance	Secondary Insurance
Subscriber: ____________________________________	Subscriber: ____________________________________
Relation: ☐ Self ☐ Spouse ☐ Other: _______________	Relation: ☐ Spouse ☐ Other: ______________________
Insurance Co: __________________________________	Insurance Co: __________________________________
Policy/Plan #: ____________ Division/Sect #: _________	Policy/Plan #: ____________ Division/Sect #: _________
Subscriber I.D. _______________ SIN _______________	Subscriber I.D. _______________ SIN _______________
Are You Familiar with Your Plan Details? ☐ Yes ☐ No	Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Method of Payment ☐ Cash ☐ Cheque ☐ Credit Card: ______________ Number: ____________ Exp.: ________

MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

The following information is required by the dentist to assist in proper diagnosis and treatment. ☐ Yes ☐ No

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? ____________ ☐
   Please specify: ____________
2. Are you presently under the care of a physician? ____________ ☐
   so, please explain: ____________
3. Have you had a medical examination in the last year? ____________ ☐
4. Do you use any prescription or non-prescription drugs regularly? ____________ ☐
   Please specify: ____________
   ____
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? ____________ ☐
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? ____________ ☐
   Please specify: ____________
7. Have you been hospitalized in the last 5 years? ____________ ☐
   Please specify: ____________
8. Have you ever experienced any unusual reaction to any of the following? (Please circle) ____________ ☐
   local anesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? If so please explain ____________
9. Have you been warned against taking any drug or medication? ____________ ☐
10. Do you bruise easily or bleed abnormally? ____________ ☐

Have you ever had any organ implants or medical implants? ____________ Yes ☐ No ☐

Have you ever fainted? ____________ ☐ ☐

Do your ankles swell? ____________ ☐ ☐

Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ____________ ☐ ☐

Do you have frequent headaches? ____________ ☐ ☐

Do you have A.I.D.S. or have you ever tested positive for H.I.V.? ____________ ☐ ☐

Do you have any of the following? Please check any that apply ____________ ☐ ☐

Heart Murmur or mitral Valve Prolapse ☐	Malignant Hyperthermia ☐	Liver Disease ☐	Herpes
Stomach / Intestinal Problems / Ulcers ☐	Drug / Alcohol Dependency ☐	Heart Attack ☐	Sinus Trouble
Joint Replacement (hip, knee, etc.) ☐	Venereal Disease ☐	Cold Sores ☐	Stroke
Dental or Nervous Disorder ☐	Lung Disease (i.e. Asthma) ☐	Jaundice ☐	Kidney Problems
Blow Blood Pressure ☐	Thyroid Discase ☐	Diabetes ☐	Emphysema
Hyper (hypo) Glycerin ☐	Arthritis or Rheumatism ☐	Tuberculosis ☐	Glaucoma
Epilepsy or Seizures ☐	Scarlet or Rheumatic Fever ☐	Hepatitis A,B,C	
Carlson / Steroid Therapy ☐	Cancer / Chemotherapy ☐	Other: _______ _______	

Have you had any injury, surgery or x-ray therapy to your face or jaws? ___________________________ ☐ ☐

Do you have any disease, condition or problem that you think the doctor should know about? _________ ☐ ☐

WOMEN ONLY.

Are you pregnant or suspect you might be? If so, what month are you in? _________________________ ☐ ☐

Are you taking birth control pills? ____ ☐ ☐

Are you nursing? ____ ☐ ☐

DENTAL HISTORY

1. Reason for today's visit: Exam Cleaning Emergency Other ____________________

Are you presently having dental pain? ____ ☐ ☐

Is there a dental problem you would like to take care of as soon as possible? ______________________ ☐ ☐

Please specify: ____

2. How tranquilly do you see your dentist? 6 months Yearly Other _________________________

Former dentist: _______________________________________ Last dental visit: ___________________________

Last cleaning: _____________________________ Full mouth series of x-rays: ___________________________

3. How often do you brush your teeth? _____________________________ Floss? ________________________

4. Do your gums bleed easily? ____ ☐ ☐

5. Are your teeth sensitive to: Hot Cold Biting Sweets? ______________________ ☐ ☐

6. Do you feel you have bad breath at times? ____ ☐ ☐

7. Have you ever had jaw joint surgery? ____ ☐ ☐

8. Do you have pain in your jaw joints or suffer from migraine headaches? _________________________ ☐ ☐

9. Does any part of your mouth hurt when clenched? ____ ☐ ☐

10. Does any part of your mouth hurt when clenched? ____ ☐ ☐

11. have you had: Braces Oral surgery Gum treatment Root canal __________________ ☐ ☐

12. Do you grind or clench your teeth during the day or night? __________________________________ ☐ ☐

13. Do you smoke? Number per day: ____ ☐ ☐

14. Do you or does any family member have a problem with snoring? ____________________________ ☐ ☐

15. Have you ever experienced any growths or sore in your mouth? If so, where? __________________ ☐ ☐

16. Previous problems with dental treatment? Specify: ____ ☐ ☐

17. Are you satisfied with the appearance of your teeth? ______________________________________ ☐ ☐

Please Specify: ____

18. Other Dental Concerns:

Office policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it may be necessary to charge for the time lost. Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required and consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine and I will assume responsibility for fees associated with these services.

(Signature)

Date: