PARK PLACE DENTAL

Welcome to our Dental Practice!

Please be so kind as to complete this form. We thank you for your time.

(a parent, guardian or substitute decision maker will be responsible for decisions on my treatment ☐ yes ☐ no)

Name:_____

Street Address:_____

City:_____Postal Code:_____

Date of Birth:_____ (*DD/MM/YYYY)*

Home phone:_____

Work phone:_____

Cell phone: _____

E-mail address:_____

Preferred method of contact? (check one):

☐ ***Home #*** ☐ ***Cell #*** ☐ ***Work #*** ☐ ***Email Address***

How did you hear about our practice?

☐ Website ☐ Referral ☐ Mailer ☐ Opencare ☐ Front Signage ☐ Others

Emergency Contact: _____

Telephone:_____

Do you have dental insurance? ☐ Yes ☐ No

If yes, please provide us with your dental insurance card.

Did you know that we have a finance program called "Health Smart" where you get instant approval for credit online? We also offer an in house payment plan for bigger treatments. Ask us for more detail.

Dental History

What is the reason for today's visit?

_____

When was your last dental check up? _____

Reason for leaving last dentist? _____

Do you regularly have dental cleanings done? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

If No, please explain what you would like to change_____

Have you had a bad experience in a dental office? ☐ Yes ☐ No

If Yes, please explain_____

Medical History

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

(Women) Do you use prescribed birth control ☐ Yes ☐ No

Are you pregnant ☐ Yes ☐ No

Are you nursing ☐ Yes ☐ No

If you ever had any of the following medical conditions listed below, please check:

☐ Anemia/Radiation treatment
☐ Artificial Bones / Joints / Valves
☐ Arthritis
☐ Asthma
☐ Blood Transfusion
☐ Cancer / Chemotherapy
☐ Emphysema / Glaucoma
☐ Drug / Alcohol Abuse
☐ Cholesterol
☐ Epilepsy / Seizures / Fainting Spells
☐ Heart Murmur
☐ Heart Surgery / Pacemaker
☐ Hemophilia / Abnormal Bleeding
☐ Hepatitis
☐ High / Low Blood Pressure
☐ HIV / AIDS
☐ Hospitalized for any reason
☐ Kidney problems
☐ Mitral Valve Prolapse
☐ Psychiatric Problems
☐ Rheumatic / Scarlet Fever
☐ Severe / Frequent Headaches
☐ Shingles
☐ Sinus Problems
☐ Tuberculosis (TB)
☐ Ulcers / Colitis
☐ Venereal Disease
☐ Diabetes

You don't have to fear dentistry anymore. We offer three different levels of sedation. Please ask us for more detail.

Please list any serious medical conditions or recent surgeries you had:

_____

Are you taking any prescription by physician or over the counter drugs? ☐ Yes ☐ No

If yes, please list each one:

_____

Do you require premedication? ☐ Yes ☐ No

Are you allergic to any of the following? If so please circle.

☐ Aspirin ☐ Erythromycin ☐ Penicillin ☐ Codeine

☐ Jewelry / Metals ☐ Tetracycline ☐ Dental Anesth ☐ Latex

Please list any other allergies:_____

I understand that the information that I have given today is correct to the best of my knowledge and this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____ _____

Patients Signature | Doctor's Signature | Today's Date