KING STREET
ORTHODONTICS
The Road To A Beautiful Smile

Welcome To Our Office

Today's Date _____

Please print clearly

Your medical and dental history are essential for the determination and course of your treatment inour office. It is important that you complete this questionnaire accurately as it will become part of your office record. Be assured that it will be held in the strictest of confidence.

Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Last Name _____ First Name _____ Middle Initial ___ Birth Date (Y/M/D) ___ / ___ / ___

Home Address _____ Apt.# _____ City _____ Postal Code _____

Home Te. Number (___) _____ Business Tel. Number (___) _____ Cell (___) _____

Occupation _____ Employer _____ Do you have dental insurance? Yes ☐ No ☐

Name of Insurance Company _____ Policy # _____ Certificate / I.D. # _____

Name of Spouse/Parent _____ Business Tel. (___) _____

Family Dentist _____ Tel. Number (___) _____

Family Physician _____ Tel. Number (___) _____

Who may we thank for referring you to us? _____ Nickname: _____

Health History

How are you feeling? I am: ☐**RELAXED** ☐**NERVOUS** ☐**TERRIFIED**

Have you ever had an unfavourable reaction following dental treatment?
Please discuss this with the doctor. **YES** ☐ **NO** ☐

Female patients, are you or could you be pregnant or nursing? **YES** ☐ **NO** ☐

Check any of the following which you have or have had:

- ☐ Heart trouble/Angina
- ☐ Heart murmur
- ☐ Asthma
- ☐ Diabetes
- ☐ Arthritis
- ☐ Jaundice
- ☐ Stroke
- ☐ Hemophillia
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hepatitis A
- ☐ Addictions
- ☐ TMJ problems
- ☐ HIV + /Aids
- ☐ High blood pressure
- ☐ Anemia
- ☐ Rheumatic fever
- ☐ Lupus
- ☐ Nervous disorders
- ☐ Cortisone treatment
- ☐ Psychiatric treatment
- ☐ Migraine/Headaches
- ☐ Emphysema
- ☐ Herpes
- ☐ Hepatitis B
- ☐ Veneral disease
- ☐ Congenital heart defect
- ☐ Cardiac pacemaker
- ☐ Stomach ulcer
- ☐ Kidney disease
- ☐ Fainting spells
- ☐ Sinus trouble
- ☐ Neck injury
- ☐ Cancer treatment
- ☐ Sickle cell disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Alcoholism
- ☐ Mitral valve prolapse
- ☐ Artificial valve, joint, or prosthesis
- ☐ Blood transfusions
- ☐ Tuberculosis (TB)

Do you have or have you had any other diseases or medical problems **not** listed on this form? _____

_____

_____

Please list allergies to medications/other substances

_____

_____

Please list medications currently being taken
(include non-prescription drugs)

_____

_____

_____

Dental History

Reason for visiting (How can we help you) _____

_____

Are you presently in **pain**? ☐ YES ☐ NO
Are any of your teeth **sensitive** to the following?
☐ Hot ☐ Cold ☐ Biting Pressure
☐ Sweets ☐ Other _____

I herby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if any medicines change, I will inform the doctor at the next appointment without fail, if deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

Financial Policy: The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but business like understanding between doctor and patient. We feel that misunderstandings can be minimized if financial policies are made to aquaint you with our policy.

If you have any questions regarding insurance, billing or financial policy feel free to discuss this with our receptionist.

Broken appointments and surgical intervention may constitute an additional fee. All fees are payable upon completion of treatment.

_____

Signature **Date**