Welcome to Barrie Endodontics

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐

Name: Last:________________________ First:___________________ Middle Initial:______ Preferred:__________________

Address: ____

City: ____

Postal Code: ____ Email: ______________________________________

Home Phone: ____ Occupation: _________________________________

Work Phone: ____________________________ Ext:________ Employer / School: ___________________________

Cell Phone: ____

Best number to reach you: ☐ Home ☐ Work ☐ Cell

Referred By: ______________________________________

General Dentist: ___________________________________

Date of Birth: Day_____ Month_______ Year________ Family Physician: ________________________________

In Case of Emergency Notify: __________________________Relation:____________________Phone:___________________

If you are under 18 years of age, who is responsible for this account? ☐ Parent ☐ Legal Guardian

Name: ____ Telephone: _________________________________

Address: ____ Postal Code: _______________________________

Primary Insurance

Subscriber: ___________________________________

Date of Birth: Day:____ Month:_______Year:_____

Relationship: ☐ Self ☐ Spouse ☐ Other: ______

Insurance Company: ___________________________

Group/Policy #: _______________________________

Certificate/ID #: ______________________________

Division/Section #: ____________________________

Secondary Insurance

Subscriber: ___________________________________

Date of Birth: Day:____ Month:_______Year:_____

Relationship: ☐ Self ☐ Spouse ☐ Other: ______

Insurance Company: ___________________________

Group/Policy #: _______________________________

Certificate/ID #: ______________________________

Division/Section #: ____________________________

Do Any of the Following Apply to You?

	Yes	No
Fear of dentists	☐	☐
Pain in jaw, face or mouth	☐	☐
Bleeding gums	☐	☐
Loose teeth	☐	☐
Bad breath / Bad taste	☐	☐
Abscesses or swelling	☐	☐
Sensitive teeth to hot or cold	☐	☐
Missing teeth	☐	☐
Dry mouth	☐	☐
Sinus problems	☐	☐

	Yes	No
Food wedging between teeth	☐	☐
Shifting of teeth	☐	☐
Grinding / Clenching of teeth	☐	☐
Pain in ears	☐	☐
Frequent headaches	☐	☐
Jaw joint pain	☐	☐
Difficulty or pain on opening	☐	☐
Previous gum surgery	☐	☐
Previous trauma to teeth	☐	☐
Previous root canals	☐	☐

***Please turn over to complete page 2**

Medical Questionnaire

What medical conditions do you have that we should be aware of? ______________________________

What medical conditions are you under the care of a physician for? ______________________________

What have you ever been hospitalized or had an operation for? ______________________________

What drugs, medicines, or pills of any kind are you taking? ______________________________

What allergies or sensitivities of any kind do you have? ______________________________

Have you been warned against taking any drug or medication? ______________________________

Have you ever had radiation treatment or chemotherapy? ______________________________

Do you smoke or use chewing tobacco? ______________________________

Do Any of the Following Apply to You?

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Bleeding Disorders	☐	☐
Heart Murmur	☐	☐	Tuberculosis	☐	☐
Stroke	☐	☐	Asthma	☐	☐
Heart Attack	☐	☐	Epilepsy	☐	☐
Valve / Joint Replacement	☐	☐	Jaundice	☐	☐
Congenital Heart Lesions	☐	☐	Hepatitis	☐	☐
High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Pacemaker	☐	☐	Blood Disorders	☐	☐
Thyroid Problems	☐	☐	Diabetes	☐	☐
Arthritis	☐	☐	Sexually Transmitted Disease	☐	☐

Women Only:

Are you pregnant or suspect that you might be? ______________________________

Are you nursing? ______________________________

General Release

I, the undersigned, certify that I have provided an accurate and complete health history and have not knowingly omitted any information. I have understood all of the questions asked, and have had the opportunity to ask questions and receive explanations regarding my health history. Should there be any change in my health status in the future, I will advise this dental office. I agree to any diagnostic procedures or x-rays that may be required. I also consent to having my physician or other health care professionals contacted regarding my current health status.

Patient / Guardian Signature: ______________________________ Date: ______________

Reviewing Dentist: ______________________________