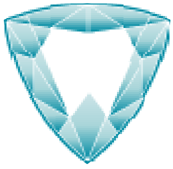


Trilliant Dentistry

Name: ____

Date of Birth: ____________________ Are you nervous of dental treatment? _____________

Address: ____ Postal code: _______________

Home Phone: _____________ ____________ Cell Phone: __________________________

E-Mail: ____

Family Doctor: _________________________________ Phone: _________________________

Who referred you to our Office? __________________ Drivers Licence # _________________

In Case of Emergency, we should notify
Name: __________________________________
Relationship: ____________________________
Phone Number: ___________________________

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. **Please fill in the entire form.**

1. Are you being treated for any medical condition at the present or have you been treated within the past year? Yes No If yes why?

____

2. When was your last Family Doctor medical checkup? _________________________________
3. When was your last Dental Visit? ____
4. Has there been any changes in your general health in the past year? Yes No If yes, please explain.

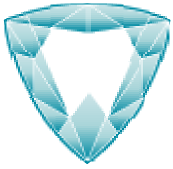
____

5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

Please List:
____

6. Do you have any allergies? If you answered yes, please list using the categories below: Yes No

A) Medications ____
B) Latex/Rubber products ____
C) Other e.g. Hay fever, Food ____



Trilliant Dentistry

7. Have you ever had an adverse reaction to any medicines or injections? Yes No

If yes, please explain: ____

8. Do you have, or have you ever had asthma? Yes No
9. Do you have, or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever, heart valve replacement? Yes No If yes please circle.
10. Do you have, or have you ever had any heart/blood pressure problems? Yes No
11. Do you have a prosthetic or artificial joint? Yes No
12. Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes No
13. Do you have any conditions or therapies that could affect your immune systems e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Yes No If yes please circle.
14. Have you ever had hepatitis, jaundice or liver disease? Yes No If yes please circle
15. Do you have a bleeding problem? Yes No
16. Have you ever been hospitalized for any illness or operations? If yes please explain. Yes No

____

17. Do you have or have you ever had any of the following? Please Circle.

Arthritis	Heart Attack	Shortness of Breath	Cancer	Kidney Disease
Steroid Therapy	Chest Pain	Lung Disease	Stomach Ulcers	Diabetes
Pacemaker	Stroke	Diet Pill Therapy	Thyroid Disease	Prosthetic Heart Valve
Drug/Alcohol Dependency		Seizures(epilepsy)	Tuberculosis	High Blood Pressure

18. Are there any conditions/diseases not listed above that you have or had? If so, what?

____

19. Are there any diseases or medical problems that run in your family? Yes No Please list.

____

20. Do you smoke or chew tobacco products? Yes No
21. **For Women Only**: Are you breast-feeding or pregnant? Yes No

If pregnant, what is the expected delivery date? ____

Signature of patient, Parent, or Guardian: _________________________ Date: ____________________

Signature of Dentist: ____ Date: ____________________