32 PEARLS DENTAL

Confidential Patient Record

Name:_____
Last First Middle

Birth Date:_____ NS Health Card #:_____
Day/Month/Year

Parents/Guardians (if applicable):_____

Address:_____
Street City Province Postal Code

Telephone: Home:(___)_____ Work:(___)_____

Cell:(___)_____ Would you like a text reminder for Appointments: YES/NO

Email:_____ Would you like an email reminder for your appointments: YES/NO

Physician:_____ Telephone:(____)_____

In case of emergency Call:___ _____ Telephone:(____)_____

Dental Insurance: Yes/No If yes, please give information to front desk.

How did you hear about us? _____

Medical and Dental History

	YES	NO
Are you being treated for any medical condition at present, or have you been treated within the past year? If yes, please explain.....	☐	☐
When was your last medical check-up?.....		
Has there been any change in your general health in the past year? If yes, please explain.....	☐	☐
.....		
Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? If yes, please list.....	☐	☐
Do you have any allergies? If yes, Medications ☐ Foods☐ Latex/Rubber Products ☐ Nickel ☐ Silver ☐ Other Metals ☐ list if needed.....	☐	☐
Have you ever had an adverse reaction to any medication or injections?.....	☐	☐
Have you ever been hospitalized? If yes, please explain.....	☐	☐

Have you have or ever had (Please Circle):

Allergy	Epilepsy/Seizures	Kidney Disease
Asthma	Cancer	Diabetes
Hives or Skin Rash	Thyroid Disease	High or Low Blood Sugar
Blood/Bleeding Disorder	Mental Nervous Disorder	Lung Disease
Heart Disease	Stomach Problems/Ulcers	Arthritis
High/Low Blood Pressure	Liver Disease	HIV/AIDS
Stroke	Hepatitis	Venereal Disease
Leukemia	Heart Murmur	Drug/Alcohol Dependency
Chest pain/Angina	Radiation Therapy	Chemotherapy
Shortness of Breath	Sleep Apnea	Rheumatic Fever
Tuberculosis	Acid Reflux	Steroid Therapy
Pacemaker	Bulimia/Anorexia	Infection of the Heart (Infective Endocarditis)
Replacement or repair of a Heart Valve	Heart Condition from Birth /Congenital	Heart Transplant

If any circled above, please explain .....
.....

Are there any conditions or diseases not listed above that you have or had? If yes, explain.....
.....

Are there any disease or medical problems that run in your family? If yes, explain.....
.....

Women only, Are you pregnant? Yes/No If yes, How many weeks?.....

Name: .....

Social History

Do you use any tobacco or cannabis products? If yes, what type and frequency.....
Do you drink alcohol? If so, how much per week?.....
Do you use any controlled or recreational drugs such as cocaine, ecstasy, LSD or heroin? If yes, what and frequency.....

Dental History

	YES	NO
How important is it to you to keep your teeth and gums healthy for the rest of your life; on a scale of 1-10 (10 being very important)?	_____	
Do you have any dental concerns?.....	☐	☐
Are you happy with how your smile looks?.....	☐	☐
Do your gums bleed when you brush and/or floss?.....	☐	☐
Do you often have a bad taste or bad breath?.....	☐	☐
Do your gums get sore?.....	☐	☐
Do you have pain around your TMJ; your jaw joint, in front of your ear?.....	☐	☐
Do you grind or clench your teeth? If so, night or during the day?.....	☐	☐
Do you wake up with headaches or sore facial muscles?	☐	☐
Do you snore?	☐	☐
Do you wake up gasping for breath throughout the night (i.e. Sleep Apnea)?.....	☐	☐
Do you frequently feel sleepy during the day?.....	☐	☐
Do you experience anxiety about going to the dentist?.....	☐	☐
Are you interested in replacing missing teeth?.....	☐	☐

Do you wish your teeth were: Straighter ☐ Whiter ☐

Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep this appointment, please provide **AT LEAST 48 HOURS NOTICE**, otherwise there will be a charge for the time lost. We appreciate your consideration of this policy. I understand that I am financially responsible to my dentist for services rendered to my account.

Permit of Operations

I, the undersigned, certify that all of the above medical & dental information is true to my knowledge and that I have not omitted any pertinent information. I consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. Possible complications of treatment have been explained to my satisfaction.

Patient (Parent/Guardian) signature:..... Date:.....

Dentist signature:..... Date:.....