WELCOME TO KING RITSON DENTAL CLINIC

Today's Date_____
Please print clearly

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

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

Home Tel. Number: ( ) _____ Email address: _____
Cell Phone #: ( ) _____

Occupation _____ Employer _____
Do you have dental insurance? YES ☐ NO ☐

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

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

Emergency Contact _____ Tel. Number ( ) _____
Relationship:_____
Patient of the office? YES NO

Family Physician _____ Tel. Number ( ) _____
Address: _____

Date of Last Medical Check-up: _____
Health Card Number: _____

Pharmacy : _____ Tel. Number ( ) _____

Previous DDS name: _____ Tel. Number ( ) _____
Who may we thank for referring you to us? _____

How did you hear about our office? (please circle one) Internet Website Drive-by sign Yellow Page

HEALTH HISTORY

(PLEASE CIRCLE)

Please circle how you are feeling. I am**:** **RELAXED NERVOUS VERY NERVOUS**

Have there been any changes in your general health within the past year? **YES NO NOT SURE**
If yes, explain: _____

Have you ever been hospitalized for any medical condition or operations? **YES NO NOT SURE**
If yes, please explain: _____

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

☐ Heart trouble/Angina	☐ High blood pressure	☐ Congenital Heart Disease
☐ Heart murmur	☐ Heart Transplant	☐ Congenital Heart Defect
☐ Cardiac Pacemaker	☐ Rheumatic fever	☐ Fainting spells
☐ Diabetes	☐ Lupus	☐ Sinus trouble
☐ Arthritis	☐ Nervous disorders	☐ Neck injury
☐ Jaundice	☐ Cortisone treatment	☐ Cancer treatment
☐ Stroke	☐ Psychiatric treatment	☐ Sickle cell disease
☐ Hemophilia	☐ Migraine/Headaches	☐ Liver disease
☐ Epilepsy	☐ Emphysema	☐ Thyroid disease
☐ Glaucoma	☐ Herpes	☐ Alcoholism
☐ Hepatitis A, B, or C	☐ Infective endocarditis	☐ Mitral valve prolapse
☐ Addictions	☐ Venereal disease	☐ Artificial valve, joint, or prosthesis
☐ TMJ problems	☐ Kidney Disease	☐ Blood transfusions
☐ HIV + /AIDS	☐ Asthma	☐ Tuberculosis (TB)
☐ Stomach Ulcer	☐ Anemia	☐

Are you currently being treated for any medical condition, or been treated in the past year? **YES NO NOT SURE**
If yes, please explain: _____
Are there any
List of medications if any: _____
_____
_____
_____

Do you have any allergies? **YES NO NOT SURE** If yes, please list them using the categories below:
a) medications_____
b) latex/rubber products _____
c) other (e.g. hay fever, seasonal, foods) _____

Do you have any conditions or therapies that may affect your immune system? (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)
YES NO NOT SURE
Are there any diseases or medical problems that run in your family? (diabetes, cancer or heart disease) **YES NO NOT SURE**

Have you ever had a peculiar or adverse reaction to any medicines or injections? **YES NO NOT SURE**
If yes, please explain: _____

Do you identify as a patient with disability? **YES NO NOT SURE**
If yes, please explain: _____

Do you have a bleeding problem or bleeding disorder? **YES NO NOT SURE**

Do you have or have you ever had any heart or blood pressure problems? **YES NO NOT SURE**

Are you taking any blood thinners? **YES NO** (Warfarin, Coumadin, Plavix, Aspirin, Xarelto, Other)

Do you smoke or chew tobacco products? **YES NO** If yes, how many? _____

WOMEN: Are you breastfeeding or pregnant? **YES NO**
If pregnant, what is the expected delivery date? _____

To the best of my knowledge, the above information is correct:
Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____