

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First (Preferred Name)  
 Gender\*: \_\_\_\_\_ Preferred pronoun (optional): \_\_\_\_\_  
 Email address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Phone (CELL): \_\_\_\_\_ (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street Apartment #  
 \_\_\_\_\_  
City Province Postal Code

*\*While our clinic recognizes a number of sexes/genders, many insurance companies and legal entities do not. Please understand that the legal name and gender listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.*

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply.**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> HIV/AIDS          | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> H. Blood Pressure    | <input type="checkbox"/> Rheumatism       |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> STI              |
| <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Sinus Problems   |
| <input type="checkbox"/> Codeine           | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Seasonal          | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths            | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Tumors           |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries      | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease      | Due: _____                                    | <input type="checkbox"/> OTHER: _____     |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Murmur       | <input type="checkbox"/> Radiation Treatment  | _____                                     |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hepatitis B / C    | <input type="checkbox"/> Respiratory Problems | _____                                     |
|  |   | <input type="checkbox"/> Rheumatic Fever      |   |

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

- Have you ever had any complications following dental treatment?  
 Yes  No *If yes, please explain:* \_\_\_\_\_
  - Have you been admitted to a hospital or needed emergency care during the past two years?  
 Yes  No *If yes, please explain:* \_\_\_\_\_
  - Are you now under the care of a physician?  
 Yes  No *If yes, please explain:* \_\_\_\_\_
  - Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
  - Do you have any health problems that need further clarification?  
 Yes  No *If yes, please explain:* \_\_\_\_\_
  - Are you presently taking any kind of medication?.....  Yes  No
- Specify: A. \_\_\_\_\_ Reason: \_\_\_\_\_  
 B. \_\_\_\_\_ Reason: \_\_\_\_\_  
 C. \_\_\_\_\_ Reason: \_\_\_\_\_  
 D. \_\_\_\_\_ Reason: \_\_\_\_\_

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.**

\_\_\_\_\_  
Patient Signature

### Dental History

- How frequently do you see your dentist? .....6 Months Yearly Other: \_\_\_\_\_
- Have you had oral hygiene instruction in.....Brushing Flossing Other: \_\_\_\_\_
- Have you ever had local anaesthetic?..... Yes No Any complications: \_\_\_\_\_
- Are any of your teeth sensitive to.....Cold Sweets Heat Other: \_\_\_\_\_
- Do your gums bleed when.....Brushing Flossing Spontaneously
- Do your gums feel swollen or tender? ..... Yes No
- Do you catch food between your teeth? ..... Yes No
- Are you aware of any loose teeth? ..... Yes No
- Have you ever had a full mouth series of x-ray? ..... Yes No
- Does your jaw crack, pop or grate when you open widely? ..... Yes No
- Do you grind or clench your teeth?..... Yes No

### Smile Analysis

- Yellow, stained or discolored teeth ..... Yes No
- Gaps, or space between teeth ..... Yes No
- Missing teeth ..... Yes No
- Teeth worn down, chipped or uneven ..... Yes No
- Teeth appear too small, short, large or long ..... Yes No
- Prior dental work that appears unnatural ..... Yes No
- Crowns, bridges that appears unnatural ..... Yes No
- Gray, black or silver (mercury) fillings in your teeth ..... Yes No
- "Gummy" smile (too much gums show when smiling) ..... Yes No
- Are you self-conscious about your teeth or smile? ..... Yes No

### Referral Information

Whom may we thank for referring you to our practice?

- Dental Office Yellow Pages Newspaper School Work Other: \_\_\_\_\_
- Friend (patient) Relative (patient) .....Name: \_\_\_\_\_

### PATIENT ACKNOWLEDGEMENT AND CONSENT

I, the undersigned, certify that all above medical and dental information is true and I have not omitted any pertinent information.

I hereby consent to the performing of all dental and surgical treatments deemed necessary or advisable, including the use of local anesthetic.

I acknowledge that I will assume full responsibility for the payment of all fees associated with these procedures. I acknowledge that my insurance plan may not cover all services provided, but that I will be responsible for the full payment of all fees. If my account has an outstanding balance, I authorize Dr. Kevin Russelo and Associates to charge such balance to my credit card account on file.

I authorize the release, to my insuring company plan administrator, of the information contained in any claims submitted electronically.

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_