NORTH MAIN
FAMILY DENTAL

#108, 400 Main Street North, Airdrie, AB T4B 2N1
office@northmainfamilydental.ca
403.980.0056

New Patient Medical History

First Name		Last Name		Preferred Name	
Birthday (mm/dd/yyyy)		Age		Male Female Prefer not to say	
Address					
City		Province		Postal Code	
Home Phone		Cell Phone		Business Phone	
Email					
Occupation		Employer			

Who may we thank for your referral?

Are you currently under any medical treatment?

Date of last physical Doctor's name

Are you taking any medications including over the counter medications and herbal supplements?

Yes No Please specify

Any allergies, or allergies to medications or latex?

Please select if you have or have ever had the following:

- Abnormal bleeding / Hemophilia
- Acid reflux
- Anemia
- Arthritis
- Asthma or Hay fever
- Artificial Joints
- Cancer (Type)
- Chemo / Radiation
- Cold sores
- Diabetes
- Dizziness / Fainting
- Drug / Alcohol Dependency
- Stroke / Heart attack / Heart Disease
- Epilepsy
- Heart valve replacement
- Hepatitis / HIV
- High / Low blood pressure
- Immune disorders
- Kidney disease
- Liver disease
- Mental disorders
- Pacemaker
- Respiratory problems / COPD
- Sinus problems
- Steroid therapy
- Any surgeries? (Date)

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Is there any other medical information we need to know?

Females only: Are you taking birth control pills? Are you pregnant? Due date:

Are you nursing?

Do you have any pain? If so where?

How often do you see a dentist?

Name of previous dentist?

How often do you brush your teeth? How often do you floss?

Do your gums bleed easily? Yes No

Are your teeth sensitive to the following? Hot Cold Sweets Biting

Any concerns with bad breath?

Do you have pain in your jaw joints? clicking / cracking jaws when opening? Have you been diagnosed with TMJ or have trouble with long dental appointments? Please describe:

Do you clench or grind your teeth? Do you snore?

Have you ever had a sleep study? Do you smoke?

Have you had any previous problems with dental treatment?

Are you nervous during dental treatment? Please rate on a scale from 1-10 with 10 being the highest.

Do you have any problems getting numb from dental treatment?

Is there anything you would like to change about your smile?

Are you interested in more information on any of the following services?

Cosmetic Dentistry Invisalign

Whitening Botox

Patient Signature (Parents if a minor) Date

Doctor Signature Date