SUNRISE DENTAL

Adult New Patient Form

Personal Information:

Name: _____ Male ☐ Female ☐
(Last Name) (Legal First Name) (Preferred Name)

Date of Birth: _____/_____/_____ Alberta Health Care # _____
(Day) (Month) (Year)

Home Address: _____

City _____ Province _____ Postal Code _____

Home Phone #: (_____)_____ Cell #: (_____)_____

E-mail Address: _____

**Our system will text and/or email appointment reminders to you.

Employment Information:

Employer Name: _____

Occupation: _____ Phone #: (_____)_____

Address: _____
(Street) (City) (Province) (Postal Code)

Spouse Information:

Name: _____ Date of Birth: _____/_____/_____
(Last Name) (First Name) (Day) (Month) (Year)

Do you have Insurance? Yes ☐ No ☐ (If yes, please give your insurance card to the receptionist with this form)

If the insurance is not under your name, whose name is it under? _____
(name/date of birth)

Who may we thank for referring you? _____

In case of emergency, we should notify: _____
(Name) (Relationship) (Phone #)

Family Doctor: _____
(Name) (Phone#)

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 all the following.

1. Date of Last Dental Visit _____ Reason for Visit _____
2. When was your last medical check-up? _____
3. What is your current approximate height and weight? _____
4. Are you being treated for any medical condition at present, or have you been treated within the last year?
   If yes, please list _____ Yes ☐ No ☐
5. Has there been any general change in the past year? ..... Yes ☐ No ☐
   If yes, please explain. _____
6. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ... Yes ☐ No ☐
   If yes, please list. _____

7. Do you have any allergies? ..... Yes☐ No☐
   If yes, please list. _____

8. Have you ever had a peculiar or adverse reaction to any medications or injection? ..... Yes☐ No☐
   If yes, please describe. _____

9. Have you ever had any hip, knee, or other joint replacements? ..... Yes☐ No☐

10. Have you ever been advised by your doctor to take antibiotics before dental treatment? ..... Yes☐ No☐

11. Do you or have you ever had any of the following? (Please check / circle)

☐ HIV/AIDS/Leukemia	☐ Anemia	☐ Arthritis/ Rheumatism
☐ Artificial Joints	☐ Asthma/Shortness of Breath	☐ Blood Disease
☐ Cancer/Chemotherapy	☐ Diabetes Type: 1 2	☐ Dizziness/Vertigo
☐ Drug/Alcohol Dependency	☐ Eating Disorders _____	☐ Endocrine Disorders
☐ Epilepsy/Seizures	☐ Excessive Bleeding/Bruising	☐ Fainting
☐ Glaucoma	☐ Growths	☐ Hay Fever
☐ Head/Neck Injuries	☐ Heart Disease/Heart Attack	☐ Heart Murmur
☐ Hepatitis A/B/C (Circle)	☐ High Blood Pressure	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease/Jaundice	☐ Mental Disorders
☐ Nervous Disorders	☐ Pacemaker	☐ Radiation Treatment
☐ Respiratory Disease/COPD	☐ Rheumatic Fever/Scarlet Fever	☐ Sinus Problems
☐ Sleep issues/Sleep Apnea/snoring	☐ Stomach Problems	☐ Stroke
☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Venereal Disease	☐ Codeine Allergy	☐ Penicillin Allergy
☐ Latex Allergy	☐ Other Allergies: _____	

12. Are there any conditions or diseases not listed above that you have or have ever had? ..... Yes☐ No☐
    If so, what? _____

13. Have you ever been hospitalized for illness, injury, surgery? _____

14. Are there any diseases or medical problems that run in your family? ..... Yes☐ No☐
    If so, which? _____

15. Do you smoke or chew tobacco products, use e-cigarettes (vaping) or marijuana? ..... Yes☐ No☐

16. **For women only:** Are you breast feeding or pregnant? ..... Yes☐ No☐
17. If pregnant what is your expected date of delivery? _____

Dental Information

18. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) _____
19. Have you ever had complications from past dental treatment? ..... Yes☐ No☐
20. Have you ever had trouble getting numb or had a reaction to local anesthetic? ..... Yes☐ No☐
21. Do you frequently get food caught between any teeth? ..... Yes☐ No☐
22. Do you have problems with your jaw joint? ..... Yes☐ No☐
23. Do you wear or have you ever worn a bite appliance? ..... Yes☐ No☐
24. What do you dislike the most about dental treatment? _____
25. Do you have teeth that you feel are loose? ..... Yes☐ No☐
26. Do you have specific areas that you feel are sensitive? ..... Yes☐ No☐
27. Do you know if you clench or grind your teeth whether at night or during the day? ..... Yes☐ No☐
28. Are you interested in changing the appearance of your teeth in any way? ..... Yes☐ No☐

To the best of your knowledge, all the above information is correct:

_____ _____

Patient Signature Date