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 or email appointment reminders to you. Please let us know which method you prefer

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? ______________________________

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 of the following.

1. Date of Last Dental Visit____________________ Reason For Visit ___________________________
2. When was your last medical check-up? ____
3. Are you being treated for any medical condition at the present or have you been treated within the last year? Yes ☐ No ☐
   If yes, please list ____

4. Has there been any general change in the past year? Yes ☐ No ☐
If yes, please explain.______________________________

5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes ☐ No ☐
If yes, please list.______________________________

6. Do you have any allergies? Yes ☐ No ☐
If yes, please list. ______________________________

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

8. Have you ever had any hip, knee or other joint replacements? Yes ☐ No ☐
If yes, which ______________________________

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

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

☐ AIDS	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Disease
☐ Cancer	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Growths	☐ Hay Fever
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis A/B/C (Circle)	☐ High Blood Pressure	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ Pacemaker	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Venereal Disease	☐ Codeine Allergy	☐ Penicillin Allergy
☐ Latex Allergy	☐ Other Allergies: ______________	

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

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

13. Do you smoke or chew tobacco products? Yes ☐ No ☐

14. Are you nervous during dental treatment? Yes ☐ No ☐

15. **For women only:** Are you breast feeding or pregnant? Yes ☐ No ☐

If pregnant what is your expected date of delivery? ______________________________

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

______________________________ ______________________________
Patient Signature Date