

## WELCOME TO DR. COWARD'S OFFICE

LAST NAME		FIRST NAME		INITIAL	DATE OF BIRTH Y/M/D	EMAIL
ADDRESS			CITY/PROVINCE		POSTAL CODE	WORK PHONE NUMBER
HOME PHONE NUMBER	CELLULAR NUMBER	OCCUPATION		EMPLOYER	DO YOU HAVE DENTAL INSURANCE?	
EMERGENCY CONTACT NAME			NUMBER		HOW DID YOU HEAR ABOUT DR. COWARD'S OFFICE?	

### PRIMARY DENTAL INSURANCE

### SECONDARY DENTAL INSURANCE

NAME OF INSURED		DATE OF BIRTH Y/M/D	EMPLOYER	NAME OF INSURED		DATE OF BIRTH Y/M/D	EMPLOYER
INSURANCE CARRIER		GROUP POLICY #	DIVISION	INSURANCE CARRIER		GROUP POLICY #	DIVISION
SIN # OR ID #	CERTIFICATE #	COVERAGE %	DEDUCTIBLE	SIN # OR ID #	CERTIFICATE #	COVERAGE %	DEDUCTIBLE

### HEALTH QUESTIONNAIRE

To help ensure your well being while receiving treatment in our office, please answer the following questions. All information is confidential and for our records only.

1. Have you been examined and/or treated by a physician within the last year?  
 Physician's Name and Number \_\_\_\_\_ Please Circle  
YES NO
2. Have you ever been seriously ill or hospitalized? YES NO
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? YES NO
4. Are you taking any medications or non-prescription drugs now?  
 What? \_\_\_\_\_ YES NO

Please indicate if you have had any of the following:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Rheumatic fever             | <input type="checkbox"/> Pacemaker/artificial valves     | <input type="checkbox"/> Prolonged bleeding after injury | <input type="checkbox"/> Difficulty in swallowing      |
| <input type="checkbox"/> Heart murmur                | <input type="checkbox"/> Infectious/communicable disease | <input type="checkbox"/> Bruise easily                   | <input type="checkbox"/> Frequent indigestion/vomiting |
| <input type="checkbox"/> Congenital heart condition  | <input type="checkbox"/> AIDS                            | <input type="checkbox"/> Severe headaches                | <input type="checkbox"/> Feel thirsty much of the time |
| <input type="checkbox"/> Heart attack                | <input type="checkbox"/> Positive testing for HIV virus  | <input type="checkbox"/> Sinus trouble                   | <input type="checkbox"/> Urinate more than 6x / day    |
| <input type="checkbox"/> Arteriosclerosis            | <input type="checkbox"/> Artificial joints               | <input type="checkbox"/> Sore throats                    | <input type="checkbox"/> Painful, swollen joints       |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Tumors or growths               | <input type="checkbox"/> Ear aches                       | <input type="checkbox"/> Numb/prickling sensations     |
| <input type="checkbox"/> Angina pectoris             | <input type="checkbox"/> Nervous/mental problems         | <input type="checkbox"/> Trouble hearing                 | <input type="checkbox"/> History of broken bones       |
| <input type="checkbox"/> Blood pressure problems     | <input type="checkbox"/> Epilepsy                        | <input type="checkbox"/> Shortness of breath             | <input type="checkbox"/> Tendency to faint             |
| <input type="checkbox"/> Heart trouble               | <input type="checkbox"/> Thyroid disease                 | <input type="checkbox"/> Chest pains                     | <input type="checkbox"/> Fits, seizures or convulsions |
| <input type="checkbox"/> Lung/Breathing Problems     | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Swollen ankles                  | <input type="checkbox"/> History of family disease     |
| <input type="checkbox"/> Kidney/bladder problems     | <input type="checkbox"/> Inflammatory rheumatism         | <input type="checkbox"/> Heart palpitations              | <input type="checkbox"/> Tobacco                       |
| <input type="checkbox"/> Stomach/intestinal problems | <input type="checkbox"/> Cortisone/steroid therapy       | <input type="checkbox"/> Extra pillows for sleeping      | <input type="checkbox"/> Alcoholic beverages           |
| <input type="checkbox"/> Hepatitis/jaundice          | <input type="checkbox"/> Hives/skin rash                 | <input type="checkbox"/> Persistent cough                | <input type="checkbox"/> Non-prescription drugs        |
| <input type="checkbox"/> Liver disease               | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Blood in sputum                 | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Allergies _____                 | <input type="checkbox"/> Recent change in appetite       | <input type="checkbox"/> Pregnant (how many months)    |
| <input type="checkbox"/> Blood Disorders             | <input type="checkbox"/> Unusual reaction to any drug    | <input type="checkbox"/> Foods that you cannot eat       | <input type="checkbox"/> Past menopause                |

Is there anything else concerning your health Dr. Coward should know? \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

### DENTAL HISTORY

Date of Last Dental Visit \_\_\_\_\_ Former Dentist \_\_\_\_\_ Purpose \_\_\_\_\_

Have you had regular dental care in the past?  Yes  No  
 Do you have any oral habits such as clenching, grinding your teeth, or nail biting?  Yes  No

Have you ever had tooth brushing instruction?  Yes  No  
 How often do you brush your teeth? \_\_\_\_\_

Have you ever had instruction using dental floss?  Yes  No  
 How often do you floss your teeth? \_\_\_\_\_

Are you satisfied with the function and appearance of your teeth?  Yes  No

Have you ever had or do you now have any of the following:

- |                                      |   |  |  |  |  |  |
|--------------------------------------|---|--|--|--|--|--|
| <input type="checkbox"/> Bridges     | <input type="checkbox"/> Gum Treatments   | <input type="checkbox"/> Loose Teeth   | <input type="checkbox"/> Orthodontics      | <input type="checkbox"/> Lost fillings | <input type="checkbox"/> Sensitive Teeth | <input type="checkbox"/> Injury to face or jaw   |
| <input type="checkbox"/> Extractions | <input type="checkbox"/> Partial Dentures | <input type="checkbox"/> Mouth Surgery | <input type="checkbox"/> Swelling in mouth | <input type="checkbox"/> Root Canals   | <input type="checkbox"/> Bleeding Gums   | <input type="checkbox"/> Sores or lumps in mouth |

What dental condition concerns you now? \_\_\_\_\_

Thank you. We hope that filling this form out prior to coming for your first visit was convenient for you. We look forward to meeting with you.