

Patient's LAST Name		Mr. Ms. Mrs. Dr.	Given Names (First and Middle)		Please provide numbers where we can call & message you. Circle preferred number.	
Apt -Unit	Address		City	Postal Code	Home Tel. #	
Date of Birth Day/ Month/ Year		Marital Status	E-Mail Address		Cellular #	
Social Insurance #		Government photo ID <input type="checkbox"/> copied			Business Tel. & Ext .	
Occupation / Position		Employer	Emergency Contact		Emergency Contact Tel. #	
Spouse/Partner's LAST Name		Mr. Ms. Mrs. Dr.	Given Name (First and Middle)		Cellular #	
Date of Birth Day/ Month/ Year		Social Insurance #	Business Telephone & Extension			
Occupation / Position		Employer	Business Address			
Previous DENTIST Dr.		Last Dental Visit?		PHARMACY	Telephone #	
PHYSICIAN'S Name Dr.		Telephone #		Other Health Care Provider(s)		
How did you find out about this office? (Circle All That Apply) Family Member Friend Sign Out Front Newsletter Radio Ad YellowPages (Inside) YellowPages (Backcover) Other: _____				Reason for today's visit: _____		
BENEFIT INFORMATION						
Benefits Belong To (Person)		Primary Benefits (Carrier)		Primary Group #	Primary Certificate or ID #	Division #
Benefits Belong To (Person)		Secondary Benefits (Carrier)		Secondary Group #	Secondary Certificate or ID #	Division #

It is the patient's responsibility to inform Cosmo Dental Centre immediately of any changes.

Please answer completely:

Are you under any treatment by your physician? YES NO _____
 Are you taking any prescription or non-prescription medications? YES NO _____

Do you have or have you ever had...

Any serious illnesses YES NO _____	Stomach or intestinal problems YES NO _____
Any serious surgeries YES NO _____	Have you experienced fainting or dizzy spells YES NO _____
Heart murmur YES NO _____	Do you have any environmental / food allergies? YES NO _____
Rheumatic / Scarlet Fever YES NO _____	ALLERGIES to antibiotics, or pain medications? YES NO _____ (specify) _____
Blood pressure / other Heart concerns YES NO _____	Have you been warned against / had trouble with any medications, including, local (freezing) or general anaesthetic? YES NO _____
Blood / bleeding disorders YES NO _____	Have you had any significant weight changes recently YES NO _____
Epilepsy or seizures YES NO _____	Ever had or been tested positive for any immunocompromising diseases? YES NO _____
TB (Tuberculosis) YES NO _____	Pop <input type="checkbox"/> N How Many _____ Juice/Milk <input type="checkbox"/> N How Many _____
Lung / breathing problems YES NO _____	Tea/Coffee <input type="checkbox"/> N How Many _____ Chew gum <input type="checkbox"/> N How Often _____
Liver / kidney problems YES NO _____	Smoke <input type="checkbox"/> N How Much _____ Alcohol <input type="checkbox"/> N How Often _____
Hepatitis A B C YES NO _____	Is there anything else we should know about your health? _____ _____
Diabetes YES NO _____	

WOMEN ONLY: **Currently Breastfeeding?** YES NO **Pregnant?** YES NO Not sure/Maybe **Due date:** _____

Date: _____, 20____ **Signature:** X _____

