YUKON DENTISTRY

Patient Name:			Gender: ❒Male ❒Female ❒TG
Date of Birth (D/M/Y):			❒Married ❒Single ❒Common-law ❒Child ❒Widow
Address:		City:	Postal Code:
Cell #:	Work #:		Home #:
Email Address:			
Emergency Contact:		Relationship:	Phone #:

Primary Insurance Coverage	**Secondary Insurance Coverage**
Relationship to Subscriber ❒ Self ❒ Spouse ❒ Dependant Plan Holder _____ Employer _____ Date of Birth _____ Insurance Carrier_____ Plan #_____ Member ID_____	Relationship to Subscriber ❒ Self ❒ Spouse ❒ Dependant Plan Holder _____ Employer _____ Date of Birth _____ Insurance Carrier_____ Plan #_____ Member ID_____

If you choose to provide the details of your previous dental clinic, we will contact them on your behalf and request your records be forwarded to us, prior to your upcoming dental appointment.

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____
Do you have BiteWing x-rays that are less than 1 year old? _____
Date of last cleaning and exam _____

Name of previous Dental office: _____
City _____ Phone # _____

Do you smoke or vape? If so, what kind and how much? _____
List of Medications (if you have not provided one to be scanned into your file):

_____

_____

List any allergies or unfavourable reactions to medications you have had:

_____

Please indicate if any of the following conditions apply to you

AIDS/HIV Positive	YES	NO	High Blood Pressure	YES	NO
Amelogenesis imperfecta	YES	NO	Irregular Heartbeat	YES	NO
Artificial Heart Valve	YES	NO	Low Blood Pressure	YES	NO
Artificial Joint	YES	NO	Mitral Valve Prolapse	YES	NO
Asthma	YES	NO	Mouth Breathing	YES	NO
Bleeding Disorder _____	YES	NO	Mucosal erosive lichen planus	YES	NO
Blood Disease	YES	NO	Nail biting	YES	NO
Cancer _____	YES	NO	Nursing	YES	NO
Chemotherapy	YES	NO	Osteoporosis	YES	NO
Cold Sores/Fever Blisters	YES	NO	Pacemaker or Defibrillator _____	YES	NO
Congenital Heart Disorder	YES	NO	Pregnant now/Possibly Pregnant	YES	NO
COPD/ Lung Disease _____	YES	NO	Seizures/ Epilepsy_____	YES	NO
Diabetes	YES	NO	Serious operation _____	YES	NO
Eating Disorder _____	YES	NO	Sleep Apnea/ Snoring _____	YES	NO
Glaucoma	YES	NO	Strong Gag Reflux	YES	NO
Heart Attack/Failure _____	YES	NO	Substance Use _____	YES	NO
Heart Murmur	YES	NO	Teeth Grinding/ Clenching _____	YES	NO
Heart Trouble/Disease _____	YES	NO	Thumb Sucking	YES	NO
Hepatitis (A, B, or C?) _____	YES	NO	Tumors or Growths _____	YES	NO
Herpes	YES	NO	Other _____	YES	NO

The use of some substances can block the affectiveness of dental freezing, or could lead to an adverse cardiac reaction. It is important that you disclose all pharmaceutical, illicit, or herbal substances to your provider, prior to scheduling appointments for treatment. Patient confidentiality protects information you disclose to Riverstone Dental Clinic.

Health Card # _____ Name of your Physician _____

PATIENT CONSENT AND APPROVAL

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history.
I authorize the dentist to perform diagnostic procedures and treatment necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary. I understand that my responsibility for payment for all dental services provided for myself or my dependants is mine, and I will assume responsibility for fees associated with these services.

_____ _____

Signature of Patient or Parent/Guardian **Date**

_____

Print Name