



Dr A. Joy Graham  
and Associates

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### Patient Information

Date: \_\_\_\_\_ **Name** \_\_\_\_\_ Date of Birth. \_\_\_/\_\_\_/\_\_\_  
M/D/Y

Home Phone # \_\_\_\_\_ Work phone # \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's work phone # \_\_\_\_\_.

Referred by (name of friend, fellow employee, etc): \_\_\_\_\_

Family Doctor \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

### Dependent

**Children only:** Mother's Name \_\_\_\_\_ Work phone # \_\_\_\_\_

Father's Name \_\_\_\_\_ Work phone # \_\_\_\_\_

### MEDICAL HISTORY

Any Dental Concerns: \_\_\_\_\_

#### *Please circle:*

- Yes No Are you having tooth, gum or head and neck pain or discomfort at this time?
- Yes No Do you feel very nervous about having dental treatment?
- Yes No Have you ever had a bad experience in a dental office?
- Yes No Have you been a patient in a hospital during the past two years?
- Yes No Have you been under the care of a medical doctor during the past two years?
- Yes No Have you taken any medicine or drugs during the past two years?
- Yes No Are you allergic (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine or any drugs or medications?
- Yes No Have you ever had any excessive bleeding requiring special treatment?

**Check any of the following which you have had or have at present:**

Heart failure	Wheelchair Dependent	HIV
Heart Disease or Attack	Emphysema	Hepatitis
Angina Pectoris	Lung or breathing Problems	Liver Disease
High Blood Pressure	Tobacco use	Yellow Jaundice
Heart Murmur	Tuberculosis (TB)	Blood Transfusion
Rheumatic Fever	Asthma	Drug Addiction
Congenital Heart Defects	Hay Fever	Alcohol Abuse
Artificial Heart Valve	Sinus Trouble	Hemophilia
Heart Pacemaker	Allergies or Hives	Venereal Disease
Heart Surgery	Diabetes	(Syphilis, Gonorrhea)
Artificial Joint	Thyroid Disease	Cold Sores
Anemia	Cancer, Leukemia	Epilepsy or Seizures
Fainting or Dizzy Spells	X-ray or cobalt Treatment	Stroke
Kidney Trouble	Chemotherapy	Nervousness
Dialysis	Arthritis	Psychiatric Treatment
Ulcers	Rheumatism	Sickle Cell Disease
Headaches	Cortisone/Steroid Medicine	Bruise Easily
Mentally Handicapped	Glaucoma	Latex Sensitivity
Brain Injury	Pain in Jaw Joints	

Yes\_\_\_ No\_\_\_ When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are tired?

Yes\_\_\_ No\_\_\_ Have you lost or gained more than 10 pounds in the past year?

Yes\_\_\_ No\_\_\_ Do you ever wake up from sleep short of breath or sweating heavily?

Yes\_\_\_ No\_\_\_ Are you on a special diet? \_\_\_\_\_ Doctor's order or self imposed?

Yes\_\_\_ No\_\_\_ Has your medical doctor ever said you have a cancer or tumor?

Yes\_\_\_ No\_\_\_ Do you have any disease(s), conditions(s) or problems(s) not listed?

Women (a) Are you pregnant now? \_\_\_\_\_

(B) Do you take a birth control pill? \_\_\_\_\_

Please list all your current medications\_\_\_\_\_

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**DENTAL HISTORY**

Are you having dental pain? \_\_\_\_\_

Do you think you have gum problems? \_\_\_\_\_

Do you notice popping, clicking or soreness of the jaw or just in front of your ears? \_\_\_\_\_

Are you involved in any contact sports? (i.e. hockey, football, etc)\_\_\_\_\_

Have you ever had problems with dental freezing (local anesthetic)? \_\_\_\_\_

When was you last dental visit? \_\_\_\_\_ Were your last x-rays taken?\_\_\_\_\_

Do you wear complete or partial dentures? \_\_\_\_\_ How many years have you worn dentures? \_\_\_\_\_. How old are your present dentures? \_\_\_\_\_ Do you have a dry mouth? \_\_\_\_\_

**I hereby consent to have Dr. Graham and her staff provide me with dental care as mutually agree upon. To the best of my knowledge, all of the preceding answers are true and correct. If, I ever have any change in my health, or if my medicine changes, I will inform the dental staff at the next appointment without fail.**

\_\_\_\_\_

Date                      Patient's or Guardian signature                      Dentist's signature

**Please note: 24 hour notice is required for any cancellation!**