WELCOME TO THE HUBBARDS FAMILY DENTAL CLINIC
Dr. Darren DeViller, D.D.S.

PERSONAL INFORMATION (Please print) Date ____________________

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional services. All information will be kept strictly confidential.

Name: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ ______________________________
(given name) (family name)

Address: ______________________________

Date of birth: ____________________ (Day/Month/Year)

Telephone: Res. __________ Business (& ext): __________ Cell: __________

Email: ______________________________

Occupation: ____________________ Place of Business: ____________________
(of parent if under 16yrs.) (of parent if under 16 yrs)

Person responsible for account: Self ☐ Other ☐ ____________________

Dental Insurance: Yes ☐ No ☐ If yes, insurance company name: ____________________

Contract # ____________________ Group (Policy) # ____________________

Subscriber ____________________ % of Basic Coverage ____________________

Physician: Name ____________________ Telephone __________

Health Card # ______________________________

In case of emergency please notify: Name ______________________________

Relationship to patient: ____________________ Telephone __________

How did you find out about our office?

☐ Yellow Pages ☐ Walk in ☐ Google ☐ Other ☐ Referred by: ____________________

MEDICAL HISTORY

1. Are you now under the care of a physician (or have you been in the last 6 months) .... yes ☐ no ☐
   a) If so, what is the condition being treated? ____________________
2. Have you had any serious illness or operation?........ yes ☐ no ☐
   a) If so, what is the illness or operation? ____________________
3. Are you taking any drug or medicine?........ yes ☐ no ☐
   Specify: A) Drug __________ Reason __________
   B) Drug __________ Reason __________
   C) Drug __________ Reason __________
   (Please attach additional sheet/photocopy if insufficient space)
4. Are you ALLERGIC or have you every reacted adversely to any drug or medicine: *(PLEASE CIRCLE)* aspirin; codeine; penicillin or other antibiotics; local anaesthetic (freezing); analgesics (pain killers); barbiturates (sleeping pills); sedatives; sulfonamide (sulfa)
5. Do you have or have you had any of the following diseases or problems: (PLEASE *CIRCLE)*
   a) Rheumatic fever, rheumatic heart disease, or heart murmur? .... yes ☐ no ☐
   b) Congenital heart lesions? .... yes ☐ no ☐
   c) Cardiovascular disease: ie. heart trouble; heart attack; high blood pressure; arteriosclerosis (hardening of the arteries); stroke? .... yes ☐ no ☐
   d) Chest pains or shortness of breath?........ yes ☐ no ☐
   e) Prosthetic implants: ie. heart valve, shunt? .... yes ☐ no ☐
   f) Asthma, hay fever, skin rash, allergies, sinus trouble, bronchitis? .... yes ☐ no ☐
   g) Fainting spells or seizures: ie. epilepsy?........ yes ☐ no ☐
   h) Diabetes? Any family history of? .... yes ☐ no ☐
   i) Kidney disease? .... yes ☐ no ☐
   j) Hepatitis, jaundice or liver disease? .... yes ☐ no ☐
   k) Endocrine disorders: ie. thyroid disease?........ yes ☐ no ☐
   l) Breathing disorders: ie. tuberculosis, emphysema? .... yes ☐ no ☐
   m) Gastrointestinal disease: ie. ulcers? .... yes ☐ no ☐
   n) Nervous disorder?........ yes ☐ no ☐
   o) Bone, muscle or joint disorder: ie. arthritis?........ yes ☐ no ☐
   p) Cancer? .... yes ☐ no ☐
   q) Venereal disease?........ yes ☐ no ☐
   r) AIDS or AIDS-related complex? .... yes ☐ no ☐
   s) Injury, surgery, x-ray therapy to your face & jaws? .... yes ☐ no ☐
   t) Tendency to faint?........ yes ☐ no ☐
   u) Frequent to severe headaches? .... yes ☐ no ☐
6. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?........ yes ☐ no ☐
   a) Do you bruise easily?........ yes ☐ no ☐
   b) Do you have any blood disorder?........ yes ☐ no ☐
7. WOMEN - Are you pregnant? (Due Date) __________ yes ☐ no ☐
8. Do you have any disease or problem not listed above that you think we should know about?........ yes ☐ no ☐
   If so, please explain ____________________
9. Do you smoke? If so, how much __________ yes ☐ no ☐
10. Do you drink alcoholic beverages? If so, how much __________ yes ☐ no ☐

DENTAL HISTORY

1. Do your gums bleed when:
   Brushing ☐ Flossing ☐ Spontaneously ☐ .... yes ☐ no ☐
2. Do your gums feel swollen or tender? .... yes ☐ no ☐
3. Do you catch food between your teeth? .... yes ☐ no ☐
4. Are you aware of any loose or painful teeth? .... yes ☐ no ☐
5. Do you object to dental x-rays? .... yes ☐ no ☐
6. Are you nervous about dental treatment? .... yes ☐ no ☐
7. Does your jaw crack, pop, click or grate when you open wide? .... yes ☐ no ☐
8. Do you grind or clench your teeth? .... yes ☐ no ☐
9. Do you get frequent headaches or jaw pain? .... yes ☐ no ☐
10. Are you satisfied with the color, shape and appearance of your teeth? .... yes ☐ no ☐

TREATMENT CONSENT

This is to certify that I, the undersigned, consent to the dental procedures discussed and agreed to be necessary or advisable, including the use of local anaesthetic and/or x-rays as indicated. I fully understand office policy, and I will assume responsibility for fees associated with those procedures performed.

______________________________ ____________

Signature Date