Solar Dental™

PATIENT INFORMATION

ADULT ☐ **CHILD** ☐ **ADULT UNDER GUARDIANSHIP** ☐ **NAME OF GUARDIAN** ☐

Name _____ Mrs. ☐ Ms. ☐ Mr. ☐
(First) (Last)

Home Address _____
(Street) (City) (Province) (Postal Code)

Home Phone _____ Cellular Phone _____

Date of Birth _____ Age _____ Sex* _____ Marital Status _____

Family Physician _____ Phone _____

Medical Specialist (If Presently Under Care) _____ Phone _____

OCCUPATION

Employed By _____ Phone _____ Ext. _____

Spouse Employed By _____ Phone _____ Ext. _____

PERSON RESPONSIBLE FOR ACCOUNT

Self ☐ Other ☐ Name _____

Address _____

Business Phone _____ Ext. _____

IN CASE OF EMERGENCY

Please Notify _____ Relationship _____

Address _____

Home Phone _____ Business Phone _____ Ext. _____

Is any other member of your family or relative a patient at our office? _____

REASON FOR TODAY'S VISIT

Examination ☐ Emergency ☐ Other ☐ _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY

Please check YES or NO, If not sure check NS.	NO	NS	YES	
Are you presently under Doctor's Care?*				
When was your last complete physical examination?*				
Are you currently in good health?*				
Do you smoke?* How many a day? For how long?				
Do you use recreational drugs? *				
Are you presently taking any medication, pills or drugs?*				→ If YES, list them here.
Have you had any type of surgery?*				→
Have you been hospitalized in the past two years?*				
Have you ever taken cortisone/steriod medication?*				

Medications: