Health First DENTAL

Name_____ Preferred Name _____
Birthdate(dd/mm/yy) _____ Age_____ Marital Status _____ Spouse's Name _____
Address_____
City _____ Province_____ Postal Code _____
Phone #(Home) _____ (Work)_____ (Cell)_____
E-mail _____
Occupation _____Employer_____
Whom may we thank for referring you to our practice? _____

Health History

Physician's Name _____ Phone # _____ Date of Last Visit? _____
Alternative Healthcare Provider's Name (i.e. Naturopath, Osteopath, etc.) _____
Please list the following:

- Allergies (i.e. drugs, metals, latex?) _____
- Prescription medications/dosage _____
- Supplements or over the counter medications including aspirin _____

Hospitalization or emergency care during the last 5 years? Reason? _____

Indicate which of the following you have had or have at present. (Please check those that apply):

- □ AIDS/HIV Positive
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Bleeding Disorders
- □ Cancer
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Hay Fever
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis A B C
- □ High Blood Pressure
- □ Kidney Disease
- □ Liver Disease
- □ Lung Disease
- □ Lyme Disease
- □ Mental Disorders
- □ Nervous Disorders
- □ Osteoporosis
- □ Pacemaker
- □ Radiation Treatment
- □ Rheumatic Fever
- □ S.T.D's
- □ Sinus Problems
- □ Sleep Apnea
- □ Stroke
- □ Tuberculosis
- □ Thyroid Disease
- □ Other:_____

Do you smoke tobacco? _____ How much per day? _____ How many years? _____
Do you smoke e-cigarettes? _____ How much per day? _____ How many years? _____
Do you smoke cannabis? _____ How much per day? _____ How many years? _____
Do you consume alcohol? _____ How often? _____
Do you use recreational or street drugs? _____ Have you had a blood transfusion? _____

WOMEN: Are you pregnant or think you could be pregnant? _____ Due Date_____
Are you nursing? _____
Do you use birth control prescriptions? _____