

14. Have you ever had any adverse effect to any of the following: **Antibiotic-** Penicillin Sulfonamide Other **Aspirin**
Barbiturates (sleeping pills) **Codeine** **Darvon** **Local Anaesthetic** **NONE**

15. Have you ever been warned against using any other medications? Which? _____ Yes No

16. Have you ever taken prolonged medical or non-medical drugs? Which? _____ Yes No

Do you have or have you ever had any of the following? Please check those that apply.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hip replacement surgery | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Knee replacement | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Mental disorder | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Prosthetic heart valve | |

Have you ever had any illness not included above? Yes No

Specify _____

DENTAL HISTORY

1. Have you ever had a dental examination with a full series of x-rays of your teeth and jaws? Yes No

2. When was your last dental visit? _____

3. Have you ever had any complications/problems with past dental treatments? Yes No

Please explain _____

4. Have you ever had any problems/reactions to local anaesthetic? Yes No

5. Are your teeth sensitive to:

Cold Sweets Heat Other _____

6. Do your gums bleed when: Brushing Flossing Spontaneously

7. Do your gums feel swollen or tender? Yes No

8. Does food lodge between your teeth? Yes No

9. Does your jaw crack, pop or grate when opened widely? Yes No

10. Do you grind or clench your teeth? Yes No

11. Reason for today's visit: Examination and cleaning? _____ Emergency or specific problem? _____

Other? _____

Office Policy (please read)

We will help prepare insurance claim forms and assist in requesting reimbursements from insurance companies on behalf of our patients. Not all services may be covered by dental insurance and every plan has its own unique quirks and exceptions. We will do our best to help you clarify your plan. **However, it is the patient's responsibility to understand his or her own dental insurance benefits. Unless otherwise agreed upon, services are to be paid for at each visit as they are performed.**

Please help us in providing the very best of service by remembering that once you have made an appointment this time is reserved for you. Therefore, we require a minimum of **48 hours notice (2 business days)** if an appointment must be cancelled or rescheduled. **A fee may be charged or cancelled or missed appointment without sufficient notice.** Please note that insurance companies do not cover fees for broken appointments. Therefore such fees are the patient's responsibility.

I authorize Trio Dentistry to perform all dental or diagnostic procedures agreed to be necessary or advisable, including x-rays, photographs, and the use of local anaesthetic or other medications as indicated. I understand that if I miss an appointment or provide less than 48 hours notice to cancel or reschedule an appointment, I may be charged a cancellation fee. I assume full responsibility for fees associated with my dental treatment and those of my dependents. I have read and fully understand the above conditions of treatment and I accept my responsibility as a patient at this office.

Signature of patient, parent or guardian Date: _____