## 1. PERSONAL INFORMATION

( MR / MISS / MRS / MS / DR )

NAME: _____DATE OF BIRTH :_____ /_____ /_____
GIVEN NAME FAMILY NAME DAY MONTH YEAR

ADDRESS (HOME):

_____/_____/_____/_____/_____/_____
Street # Street Name Apt/ Suite# City Province Postal Code

PHONE: (HOME): _____(BUSINESS):_____(OTHER):_____

OCCUPATION: _____ EMPLOYER: _____

REFERRED BY:_____

## 2. IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME: _____ RELATIONSHIP: _____ PHONE: _____
NAME OF FAMILY DOCTOR: _____PHONE: _____

NAME OF MEDICAL SPECIALIST: _____
AREA OF SPECIALITY: _____PHONE: _____

**Do you have a regular dentist:** YES / NO **Date of your last dental visit?** _____

**Name of Dentist: _____ Phone : _____**

# General Release

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions about my medical history. I authorize the dentist to perform procedures and treatment as may be necessary and understand this treatment is for my immediate problem, and should not be regarded as a complete examination with resulting treatment. I assume responsibility for fees associated with these services and authorize release of any information regarding my diagnosis or treatment to another dentist.

**PATIENT/PARENT/GUARDIAN SIGNATURE:_____DATE: _____**

**DENTIST SIGNATURE: _____DATE: _____**