Welcome to Tottenham Village Dentistry

Please Tell Us About Yourself

First Name: _____ **Last Name:** _____ **Nickname:** _____

Date of Birth: _____ **Email Address:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Occupation: _____ **Employer:** _____

Insurance Carrier: **Group Number:**

Please check box if you have had any of these conditions			
Acid Reflux	☐	Heart Attack	☐
AIDS or HIV	☐	Heart Disease	☐
Alcohol / Drug Addiction	☐	Heart Murmur	☐
Anemia	☐	Heart Surgery	☐
Arthritis	☐	Hepatitis	☐
Artificial Heart Valves	☐	High Blood Pressure	☐
Asthma	☐	Lung Disease	☐
Bleeding Problems	☐	Mental / Nervous Disorder	☐
Chest Pains	☐	Pacemaker	☐
Diabetes	☐	Peptic / Stomach Ulcers	☐
Difficulty Breathing	☐	Sight Problems	☐
Eating Disorders	☐	Stroke	☐
Epilepsy / Seizures	☐	Thyroid Problems	☐
Glaucoma	☐	Tuberculosis	☐
Hearing Problems	☐	Other:	

Please Select "Yes" or "No" to Each Question	**Yes**	**No**
Have you ever been advised to take antibiotics before dental treatment?		
Do you carry epinephrine?		
Have you ever been treated for cancer?		
If "Yes", what type?		
Do you have any prosthetic implants (artificial joints)?		
Do you have a family history of Malignant Hyperthermia?		
Have you had an unusual reaction to local / general anesthetic or nitrous oxide?		
FEMALES: Are you or may you be pregnant?		
If "Yes", how many weeks?		
Have you had any previous surgery?		
If "Yes", what type?		

Do you smoke?		
If “Yes”, how many packs per day?		
Have you ever had any reactions to medications?		
If “Yes”, which medications?		

List Any Current Medications:	
List Any Allergies:	

Family Physician:	
Specialist Physician:	

Dental History	
How did you hear about us?	
What brings you to see us today?	
Do you have a regular dentist?	
Approximately when was your last dental visit?	
What was done at your last visit?	
Approximately when was your last set of dental x-rays taken?	
What is important to you in a dental office?	
Is there anything you liked or disliked about your previous office?	
Do you have any specific goals for your teeth, mouth or smile?	
Is there anything else you would like us to know?	

Signature: _____Date: _____

TOTTENHAM VILLAGE
Dentistry