South Windsor
1390 Grand Marais Rd. W.
Windsor, ON N9E 1E5
Phone: (519) 969-8171

COSCARELLA
FAMILY DENTISTRY

Riverside
8474 Wyandotte St. E .
Windsor, ON N8S 1T6
Phone: (519) 974-6601

Patient Name _____ Birth date _____
Mailing address _____ City _____ Postal Code _____
Home Phone _____ Cell Phone _____ Email _____
Employer _____ Occupation _____ Phone: _____ Contact at work? ☐Yes ☐No
Emergency contact name _____ Phone: _____ Relation _____

DENTAL HISTORY

Reason for today's visit _____ Date of last visit (approx.) _____
Former Dentist _____ Date of last x-rays (approx.) _____
Check (X) if you have had problems with any of the following

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Food collect between teeth
- ☐ Bad experience
- ☐ Grinding teeth
- ☐ Loose teeth / broken fillings
- ☐ Periodontal treatment
- ☐ Nervous about treatment
- ☐ Sensitive to hot
- ☐ Sensitive to sweets
- ☐ Sensitive when biting
- ☐ Satisfied with the look of your teeth
- ☐ Clicking or popping jaw
- ☐ Sensitivity to cold
- ☐ Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Phone number/City _____ Health Card# _____
Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No
Check (X) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (when _____)
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest pain
- ☐ Cortisone Treatment
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Panic Disorder
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Smoking Habit
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Leukemia

Have you had any serious illnesses or operations? _____ If yes, describe _____

MEDICATIONS

List medications you are currently taking _____

_____

_____

_____

Pharmacy Name _____

ALLERGIES

- ☐ Aspirin
- ☐ Sulfonamide (Sulfa)
- ☐ Codeine
- ☐ Local Ansethetic
- ☐ Penicillin
- ☐ Barbiturates (sleeping pills)
- ☐ Latex

Other: _____

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any information. I consent to the performing of dental procedure agreed to be necessary or advisable, including the use of local anesthetic as indicated. I will assume responsibility for fees associated with these procedures and fees not covered by the insurance. We accept Coscarella Family Dentistry to submit claims for treatment done.

Patient (Parent, Guardian) Signature: _____ Date: _____
Reviewed by: _____ Date: _____