Welcome
R and A Dentistry

Client Information

Client Name: ____ ☐ Male ☐ Female
☐ Married ☐ Single ☐ Child ☐ Other
Address: ____
Street Apartment #
____
City Province Postal Code

Phone (Home): ____________________ (Work): ____________________Cell: ______________________

E-mail address ___________________________________ Birth Date (Day/Month/Year): _____/_____/_____
Emergency contact & phone number: __________________ 65 & older AHC #_______________________

Health Information

Have your ever had any of the following? Please check those that apply:

- Addictions (i.e. drug)
- AIDS
- Allergies
- Anaemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Diabetes
- Dizziness
- Epilepsy
- Excessive Bleeding
- Fainting
- Glaucoma
- Growths
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Pacemaker
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- Stroke
- Tuberculosis
- Tumours
- Ulcers
- Venereal Disease
- Codeine Allergy
- Penicillin Allergy
- Blood Pressure
- Pulse
- OTHER:
- _____________
- _____________

Are you now under the care of a physician? Yes No
If yes, please explain: ____
Name of Physician: ____ Phone:___________________

Do you take any prescription medications or over the counter non-prescription drugs: Yes No
If yes what are the names ____

Do you have any allergies to any medications: Yes No
If yes please list ____

Are you pregnant: Yes No

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: ____

Do you have any health problems that need further clarification? Yes No
If yes, please explain: ____

Date of Last Dental Visit: _________________ Reason for this visit: ______________________________

Have you ever had any complications following dental treatment? Yes No
If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Dr. Anthony Knight at the next appointment without fail.

____ Date:___________________
Signature of client, parent or guardian