Dr. Stephanie Nigro
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TODAYS DATE	EMAIL
NAME	EMERGENCY CONTACT NAME AND PHONE NO.
DATE OF BIRTH	REFERRING DENTIST
ADDRESS W/ POSTAL CODE	FAMILY PHYSICIAN
CONTACT PHONE NO. / ALTERNATE PHONE NO.	MEDICAL SPECIALIST

INSURANCE INFORMATION	
PRIMARY INSURANCE POLICY HOLDER	SECONDARY INSURANCE POLICY HOLDER
POLICY HOLDER DATE OF BIRTH	POLICY HOLDER DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
POLICY # AND SUBSCRIBER ID	POLICY # AND SUBSCRIBER ID

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

1. Have you been a patient in a hospital and/or have had surgery? YES NO
2. Have you been under the care of a physician during the past two years? YES NO
3. Are you currently taking any medications, drugs, pills, or vitamins? YES NO
   If yes, please list or comment: ____________________

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4. Are you aware of being allergic or have you reacted adversely to any of the following medications (circle)

Aspirin, Codeine, Demerol, Ibuprofen (Advil), Nitrous Oxide, Erythromycin, Tetracycline, Metronidazole, Valium, Penicillin/Amoxicillin, Talwin, Local Anaesthetic, Other Antibiotics

5. Are you aware of being allergic to any other medications or substances (ex. latex) YES NO
   If yes, please list: ____
6. Do you smoke? YES NO

Please circle any of the following which you have had or have at present:

Heart Failure	Stroke	Rheumatism	Epilepsy
Heart Disease or Attack	Kidney Trouble	Cortisone Medicine	Fainting or Dizzy Spells
Angina Pectoris	Ulcers	Glaucoma	Psychiatric Treatment
High Blood Pressure	Tuberculosis	Pain in Jaw Joints	Nervousness
Heart Mumor	Asthma	AIDS	Bruise Easily
Rheumatic Fever	Hay Fever	Liver Disease	Abnormal Bleeding
Congenital Heart Lesions	Sinus Trouble	Yellow Jaundice	Scarlet Fever
Allergies or Hives	Hepatitis (all types)	Arthritis	Diabetes
Blood Transfusion	Heart Pacemaker	Thyroid Disease	Drug Addiction
Heart Surgery	Radiation Treatment	Haemophilia	Artificial Joints
Chemotherapy	Venereal Disease	Anaemia	Cold Sores
Artificial Heart Valve			

Others: ____

Dental History

1.	Are your teeth painful or sensitive?	YES	NO
2.	Have you noticed any swelling around your gums?	YES	NO
3.	Do your gums bleed?	YES	NO
4.	Have you noticed a change in the spaces between your teeth?	YES	NO
5.	Does food get trapped between your teeth?	YES	NO
6.	Have your gums been treated by a periodontist in the past?	YES	NO
7.	Do you clench or grind your teeth?	YES	NO
8.	Do you ever have pains/problems opening or closing your mouth?	YES	NO
9.	Have you experienced problems with local anaesthetic (freezing)?	YES	NO
10.	Are you happy with the appearance of your teeth?	YES	NO
11.	Have you had orthodontic treatment?	YES	NO
12.	Do you feel nervous at the dentist?	YES	NO
13.	When was your last dental visit?	______________	
14.	Are you pregnant?	YES	NO
15.	Are you menopausal?	YES	NO

I have read, reviewed, and agreed to how this office collects, uses, and discloses patients personal information. This is to certify that all of the above information is true.

Patients signature: ______________________________ Date ___________