Bedford DENTAL CENTRE
Diagnose · Educate · Inform · Care

Patient Information

DATE _____

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

Patient Name: _____
Last First Middle

Name of Spouse: _____
Last First Middle

Phone: _____
Res. Bus. Ext.

Address: _____
Street City Prov. Postal Code

E-mail: _____

Employer: _____

Occupation: _____

Date of birth: _____ _____
Day Month Year Gender

Family Doctor: _____
Phone

Contact for appts: _____
Name Relationship Phone

Dental Insurance? ☐ Yes ☐ No

Please provide your insurance information/card with policy / ID# to one of our receptionists.

Health Card #: _____

Previous Dentist: _____

Person responsible for account: _____

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it will be necessary to charge for the time lost.

Office policy is that services are paid for at each visit as they are performed. However in certain circumstances arrangements for payment may be made by consulting your dentist.

CONFIDENTIAL DENTAL HISTORY

1. Are you having any discomfort at this time? ☐ Yes ☐ No
   Please specify _____
2. Have you been under regular care by a dentist? ☐ Yes ☐ No
3. How long since your last dental visit? _____
4. What was done at that time? _____
   _____
5. Do your gums feel tender and swollen? ☐ Yes ☐ No
6. Are you aware of any lump or swelling in your mouth? ☐ Yes ☐ No
7. Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
8. Are you tense during dental visits? ☐ Yes ☐ No
9. Do you currently experience: *(circle the appropriate one)*

loose teeth	bleeding gums	sore gums	gagging
sensitive teeth	bad breath	popping or clicking in jaw joints	unsatisfactory dentures
ear ache	neck pain	headache	
unexplained nosebleed	missing teeth	spaced or crooked teeth	

OVER