TIM D.R. SCHANKULA

Mr. PLEASE PRINT
Mrs.
Miss Name .....
(Last Name) (First Name)

Address .....
(Number) (Street) (Apt.)

.....
(City) (Prov.) (Postal Code)

Phone: Home .....

Business .....

Occupation .....

Date of Birth..Day.....Month.....Year.....

Person responsible for account .....

Referred by .....

Dental Insurance Yes ☐ No ☐

Insurance Name .....

Group (Policy) No. .....

I.D. No. .....

Mr.
Mrs.
Miss Policy Holder Name .....

Date of Birth..Day.....Month.....Year.....

Phone: Home .....

Business .....

Employment .....

S.I.N. .....

Do you have any other Dental Insurance Coverage?

Yes ☐ No ☐

MEDICAL HISTORY

		NO	YES
1.	Have you ever had a serious illness or are you under the care of a physician now?	☐	☐
2.	Do you have shortness of breath?	☐	☐
3.	Have you ever had any type of allergy, asthma?	☐	☐
4.	Do you bleed easily or do cuts in your skin stay open a long time?	☐	☐
5.	Are you presently in good health?	☐	☐
6.	Are you presently on any special diets?	☐	☐
7.	Have you gained or lost weight recently?	☐	☐
8.	Medical Doctor? (NAME / PHONE NUMBER):	☐	☐
9.	Are you taking any medicines or drugs at the present time?	☐	☐

10. Do you have or have you had any of the following?

YES

☐ High Blood Pressure	☐ Anemia	☐ Herpes	☐ Sinus Problems	☐ H.I.V. Virus (A.I.D.S.)
☐ Low Blood Pressure	☐ Arthritis	☐ Cancer	☐ Stroke	☐ Contagious Diseases:
☐ Nervous Problems	☐ Epilepsy	☐ Psychiatric Care	☐ Tuberculosis	.....
☐ Thyroid Problems	☐ Diabetes	☐ Venereal Disease	☐ Ulcer	☐ OTHER:
☐ Heart Trouble	☐ Liver Trouble	☐ Scarlet Fever	☐ Fainting Spells	.....
☐ Chest Pains	☐ Hepatitis	☐ Asthma	☐ Kidney Trouble	.....
☐ Blood Disorders				

DENTAL HISTORY

1. Do you have dentures now? .....

If yes, Top or Bottom? ..... 2. Age of present dentures? .....

3. Who made them? ..... 4. Have they been relined? ..... Top or Bottom? .....

5. Reason of failure of present dentures? .....

6. When were your teeth extracted? ..... 7. By whom? .....

8. Were X-rays taken? ..... Approximate date? .....

9. Do your gums feel tender or sore? ..... Top or Bottom? .....

10. Do you have any lumps or sores in your mouth at this time? ..... Top or Bottom? .....

AUTHORIZATION FOR TREATMENTS

I, the undersigned, hereby consent to receive all dental treatments deemed necessary. Furthermore, I assume the full responsibility for the payment of all fees covering the aforementioned treatments.

Patient's Signature _____ Date _____