

NEW PATIENT FORM

Name:

First	MI	Last
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Address:

Street name

City	Province	Postal code
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DOB:

Year	Month	Day
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Phone:

Home	Work	Cell
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Email:

Preferred method of contact:

Emergency contact:

Name	Relationship	Phone number
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Family Physician:

Name

Clinic name

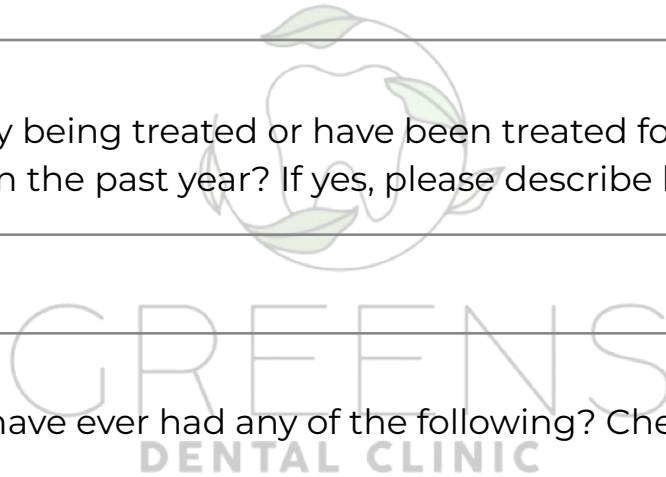
Are you taking any medications? If yes, please provide us with a complete list or list them below:

Allergies:

Are you currently being treated or have been treated for any medical conditions within the past year? If yes, please describe below:

Do you have or have ever had any of the following? Check all that apply.

- Stroke
- Asthma or emphysema
- Lung disease
- Cancer
- Diabetes
- High blood pressure
- Low blood pressure
- Heart murmur
- Heart valve repair or replacement
- Pacemaker
- Rheumatic fever
- HIV/AIDS

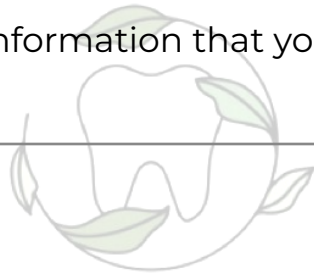


- Anxiety
- Hyper/hypoglycemia
- Shortness of breath
- Any other communicable diseases

Are you pregnant or breastfeeding?

What is the purpose of your visit today?

If you have any additional information that you wish to disclose, please do so here:



I declare that all the information I have provided on this form is true and correct:

GREENS
DENTAL CLINIC

Signature of patient

Date