

Patient Name \_\_\_\_\_ Address w/Postal Code \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
 Email \_\_\_\_\_  
 Primary Physician's Name \_\_\_\_\_ Physician Phone# \_\_\_\_\_  
 Date of Last Physical \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Spouse Name \_\_\_\_\_ Contact Phone # \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Contact Phone # \_\_\_\_\_

**Place a mark on "yes" or "no" to**

- |   |  |                        |  |                    |  |
|---|--|------------------------|--|--------------------|--|
| AIDS/HIV  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ANEMIA  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on |  |
| Arthritis, Rheumatism                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head/Neck          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep Apnea        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally,<br>with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Popping        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Limited Opening    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congested Ears     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ringin Ears        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Posture Problems   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clenching          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or dizziness                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Facial Pain        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Ache          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Lesions                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bell's palsy       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | Tonsillitis            | <input type="checkbox"/> Yes <input type="checkbox"/> No |                    |  |

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to any medications or other substances?

\_\_\_\_\_

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

\_\_\_\_yes\_\_\_\_no List Medication \_\_\_\_\_

Circle if you have seen: an Orthodontist -had your bite adjusted- had any bite related treatment - TMJ Joint Surgery

Circle if you have seen any of the following healthcare professionals: ENT, Neurologist, Chiropractor, or Massage Therapist.

Do you snore, use a CPAP or have had a sleep study?

\_\_\_\_yes\_\_\_\_no

Have you ever had radiation to the head and/or neck?

\_\_\_\_yes\_\_\_\_no

Do you use tobacco products? \_\_\_\_yes \_\_\_\_no

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Our office is conveniently located on the corner of Palladium Drive and Silver Seven Drive in Kanata, Ontario. (613) 271-7091

◆ **For those patients approaching from Highway 417 Westbound:**

Please use exit 140 Terry Fox Drive. At the lights on Terry Fox Drive, turn left. You will now cross over the highway and will turn right at the next lights at Palladium Drive. On your right you will pass a hotel, then an office building, and after that office building you will see a driveway immediately after on your right, turn in there. Follow the parking lot around to the north side of the building to the parking in front of our door (NOT the main entrance to the building). Welcome!

◆ **For those patients approaching from Highway 417 Eastbound:**

Please use exit 140 Terry Fox Drive. At the top of the exit, turn right onto Terry Fox Drive. The next set of lights is Palladium Drive, please turn right. On your right you will pass a hotel, then an office building, and after that office building you will see a driveway immediately after on your right, turn in there. Follow the parking lot around to the north side of the building to the parking in front of our door (NOT the main entrance to the building). Welcome!

◆ **For those patients approaching from South of Ottawa via Highway 416N (including from the USA):**

Take Highway 416N to Highway 417W. Please use exit 140 Terry Fox Drive. At the lights on Terry Fox Drive, turn left. You will now cross over the highway and will turn right at the next lights at Palladium Drive. On your right you will pass a hotel, then an office building, and after that office building you will see a driveway immediately after on your right, turn in there. Follow the parking lot around to the north side of the building to the parking in front of our door (NOT the main entrance to the building). Welcome!