CONFIDENTIAL PATIENT INFORMATION

Last Name:_____
First Name:_____
Preferred Name:_____
Address:_____
_____Apt#_____
City:_____Prov_____
Postal Code_____
E-Mail:_____

Male/Female (Please Circle)
Marital Status:_____
Birth Date (DD/MM/YR)_____/_____/_____
Employer:_____
SIN#_____
Home Telephone# ( )_____
Business #( )_____Ext_____
Cellular #( )_____

YOUR INSURANCE INFO:
Insurance Co:_____
Policy/Group#_____
Division/Section_____
I.D./Certificate#_____
Social Insurance#_____
Subscriber's Name:_____
Subscriber's Birthdate:_____/_____/_____
Subscriber's Employer:_____

SPOUSE'S INSURANCE INFO:
Insurance Co:_____
Policy/Group#_____
Division/Section_____
I.D./Certificate#_____
Social Insurance#_____
Subscriber's Name:_____
Subscriber's Birthdate: _____/_____/_____
Subscriber's Employer:_____

In case of emergency call_____
At:( )_____

Physician's Name:_____
Physician's Telephone( )_____

How did you come to choose our office for your dental care?_____
If you were referred, whom may we thank?_____

CONFIDENTIAL DENTAL HISTORY

PAST DENTAL HISTORY

Previous Dentist:_____ Phone#(If known)_____
How long were you a patient there?_____
Date of last visit:(MM/YR) _____/_____ Date of last x-rays:(MM/YR)_____/_____
Reason for last visit_____
Have you ever had:

1) Braces Yes ( ) No ( ) If yes, Date (MM/YR):_____/_____
2) Wisdom Teeth Removed Yes ( ) No ( ) If yes, Date (MM/YR):_____/_____
3) Jaw Surgery Yes ( ) No ( ) If yes, Date (MM/YR):_____/_____
4) Root Canal Yes ( ) No ( ) If yes, Date (MM/YR):_____/_____

PRESENT DENTAL HISTORY

1) Do you have a specific dental problem at the moment?.....Yes ( ) No ( )
   Please specify_____
2) Are you satisfied with the appearance of your teeth?.....Yes ( ) No ( )
   Please specify_____
3) Would you like whiter teeth?.....Yes ( ) No ( )
4) Would you like to maintain your teeth or improve them?.....Yes ( ) No ( )
   Please specify_____
5) Have the causes of dental disease (cavities, gum disease) ever been explained to you?.....Yes ( ) No ( )
6) Have you ever been shown how to care for your teeth? (Please check off the shown items)
   Brushing ( ) Flossing ( ) Rubber Tip ( ) Proxabrush ( ) Stimudent/toothpick ( )
7) Do you believe tooth loss is an inevitable consequence of aging?.....Yes ( ) No ( )
8) Do you object to any of the following?
   X-Rays ( ) Fluoride ( ) Local Anaesthetic(Freezing) ( )

9) **Do you currently experience any of the following**:

Crowded Teeth	( )	Loose Teeth	( )	Bleeding Gums	( )	Popping or Clicking Jaw Joints	( )
Spaced or Crooked Teeth	( )	Missing Teeth	( )	Sore Gums	( )	Earache/Headache	( )
Stained Teeth	( )	Grinding Teeth	( )	Bad Breath	( )	Sweet Sensitivity	( )
Discoloured Teeth	( )	Chipped Teeth	( )	Gagging	( )	Hot Sensitivity	( )
Unsatisfactory Dentures	( )	Dry Mouth	( )	Neck Pain	( )	Cold Sensitivity	( )
For Children,		Thumbsucking Habit	( )	Eats A lot of Sweets	( )	Crooked or Crowded Teeth	( )
		Bottle Given In Bed	( )	Soother Habit	( )	Involved in Contact Sports	( )

10) Are you tense during dental visits? No( ) Yes, a little( ) Moderately( ) Very tense( ) Prefer sedation( )

11) Which of the following best describes you? I am very interested in my oral health ( )
I visit the dentist fairly regularly ( )
I visit the dentist occasionally ( )
I visit the dentist only when I have to ( )

CONFIDENTIAL MEDICAL HISTORY

Your co-operation in filling out this 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.

1) **Do you have or have you ever had**:

Rheumatic Fever	Yes ( ) No ( )	High Blood Pressure	Yes ( ) No ( )	Cancer	Yes ( ) No ( )
Heart Condition	Yes ( ) No ( )	Shortness of Breath	Yes ( ) No ( )	Epilepsy	Yes ( ) No ( )
Heart Murmer	Yes ( ) No ( )	Chest Pain	Yes ( ) No ( )	Diabetes	Yes ( ) No ( )
Pacemaker	Yes ( ) No ( )	Fainting Spells	Yes ( ) No ( )	Asthma	Yes ( ) No ( )
Prosthetic Heart Valve	Yes ( ) No ( )	Hepatitis	Yes ( ) No ( )	X-Ray Therapy	Yes ( ) No ( )
Arteriosclerosis	Yes ( ) No ( )	Liver Disease	Yes ( ) No ( )	Stomach Ulcers	Yes ( ) No ( )
Stroke	Yes ( ) No ( )	Kidney Disease	Yes ( ) No ( )	Sinus Problems	Yes ( ) No ( )
Joint Replacement	Yes ( ) No ( )	Drug Dependency	Yes ( ) No ( )	Thyroid Problem	Yes ( ) No ( )
Tuberculosis	Yes ( ) No ( )	Herpes	Yes ( ) No ( )	Blood Disorders	Yes ( ) No ( )
				AIDS	Yes ( ) No ( )

2) Date of last medical examination_____

3) Are you currently under the care of a physician?..... Yes ( ) No ( )
Please Specify_____

4) Are you currently taking any pills, drugs or medication?..... Yes ( ) No ( )
Please Specify_____

5) Have you ever had any surgery, serious illness or been hospitalized?..... Yes ( ) No ( )
Please Specify_____

6) Do you have allergies to any drugs, medications, or latex?..... Yes ( ) No ( )
e.g. Penicillin. Please Specify_____

7) Are you currently in good health?..... Yes ( ) No ( )

8) Is there anything else you think you should tell me?..... Yes ( ) No ( )
Please Specify_____

9) WOMEN: Are you pregnant?..... Yes ( ) No ( ) Which Month?____

CONSENT FOR TREATMENT

I, the undersigned, certify that all of the above personal, dental and medical information is true to my knowledge and I have not omitted any pertinent information. I consent to a detailed dental examination, dental x-rays as required, and any recommended dental treatment. I understand any dental procedures will be explained to my satisfaction prior to being performed. I will assume responsibility for fees associated with these procedures.

Date:_____ Signature:_____

IF YOU HAVE DENTAL INSURANCE, PLEASE READ

I understand that my dental insurance may not cover 100% of the current Ontario Dental Association Fee Guide for all procedures (there may be 80% coverage, or a deductible, or my insurance on a previous year's fee guide). Any financial difference between the current Ontario Dental Association Fee Guide and my insurance coverage is my responsibility.

Date:_____ Signature:_____