WELCOME TO OUR DENTAL OFFICE

(For office use only)

I.D. # _____

MEDICAL ALERT _____

Date _____

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

The patient is an: Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian: _____

Name: (last) (first) (initial) Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Address: (street) (apt.#) (city) (province) (postal code)

Reason for today's visit? Examination ☐ Emergency ☐ Other ☐ _____

Is there a dental problem you would like treated immediately? _____ Preferred appt. time? _____

Home Phone: ( ) _____ Driver's Lic. No. _____ S.I.N. _____

Bus. Phone: ( ) _____ Ext. _____ Employer: _____ May we call you at work? ☐

PERSONAL INFORMATION

Prefers to be called: _____ Occupation: _____

Date of Birth: M___D___Y___ Age: _____ Sex: _____ Marital Status: _____ Name of Spouse: _____

Are other family members patients at our office? Yes ☐ Names: _____

Whom may we thank for referring you? _____

MEDICAL PRIORITY

Family Physician: _____ Phone: ( ) _____

Family Physician Address: _____

Medical Specialist: (if presently under care) _____ Phone: ( ) _____

Medical Specialist Address: _____

In case of emergency, please contact: _____ Phone: ( ) _____

Nearest relative not living with you: _____ Phone: ( ) _____

FINANCIAL INFORMATION

Person responsible for account: Self ☐ Spouse ☐ Other ☐ _____ Please complete all information if different than above.

Name: (last) (first) (initial) Phone: ( ) _____

Address: (street) (apt.#) (city) (province) (postal code)

Employed by: _____ Phone: ( ) _____

Driver's Lic. No. _____ S.I.N. _____

METHOD OF PAYMENT CASH ☐ CHEQUE ☐ CREDIT CARD ☐ OTHER ☐ _____

PRIMARY DENTAL INSURANCE

Subscriber's name:		D.O.B.	
Emp./Grp. policy holder:		Ins. yr. end	
Ins. Co.		Tel.	
Grp./Ind. policy No.		Cert. No.	
I.D./S.I.N.		Max. Coverage.	

SECONDARY DENTAL INSURANCE

Subscriber's name:		D.O.B.	
Emp./Grp. policy holder:		Ins. yr. end	
Ins. Co.		Tel.	
Grp./Ind. policy No.		Cert. No.	
I.D./S.I.N.		Max. Coverage.	

(For office use only)

	%	Max.	Ded.		%	Max.	Ded.
Basic				Periodontic			
Restorative				Prosthodontic			
Endodontic				Other			

	%	Max.	Ded.		%	Max.	Ded.
Basic				Periodontic			
Restorative				Prosthodontic			
Endodontic				Other			

DENTAL HISTORY

Please ✔ YES or NO to each question. If unsure of a question, please consult with the dentist.

	YES	NO
Are you in good dental health? Yes ☐ No ☐		
Is there a dental problem you would like treated immediately? Yes ☐ No ☐ _____		
_____		
Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____		
1. Have you been seeing a dentist regularly? _____	☐	☐
Why did you change your previous dentist? _____		
_____		
_____		
Are you unhappy with the appearance of your teeth? _____	☐	☐
and, What would you like to see changed? _____		
_____		
2. Have you ever had any of the following?		
- Periodontal Treatment? (treatment of the gums) _____	☐	☐
- Orthodontic Treatment? (to straighten or realign teeth) _____	☐	☐
- A bite plate or any other appliance? _____	☐	☐
- Your bite adjusted or teeth ground? _____	☐	☐
- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	☐	☐
If you answered "yes" to the last question, who performed the surgery? _____ When? _____		
Are you being followed up by a dental specialist? _____	☐	☐
3. Are there any growths or sore spots in your mouth? _____	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____	☐	☐
5. Have you noticed any loose teeth, or, have any of your teeth shifted? _____	☐	☐
6. Does food catch between your teeth? _____	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____	☐	☐
8. Have you been advised to take antibiotics before a dental appointment? _____	☐	☐
9. Do you use dental floss, proxabrush, rubber tip or stimudents? How often? _____	☐	☐
10. How often do you brush your teeth? _____ Do you feel that you have bad breath? _____	☐	☐
11. Have you ever experienced any of the following jaw problems:		
- Popping/clicking in your jaw joints? _____	☐	☐
- Pain in your jaw joints, around your ear, or side of your face? _____	☐	☐
- Difficulty in opening or closing? _____	☐	☐
- Pain when teeth are clenched? _____	☐	☐
- Pain or difficulty while chewing? _____	☐	☐
12. Do you have any of the following habits?		
- Do you snore? _____	☐	☐
- Have you ever been diagnosed with sleep apnea? _____	☐	☐
- Clenching or grinding your teeth while awake or asleep? _____	☐	☐
- Biting your cheeks or lips? _____	☐	☐
- Mouth breathing while awake or asleep? _____	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? _____	☐	☐
13. Do you have any emotional concerns about having dental treatment? _____	☐	☐
14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____	☐	☐
_____		

MEDICAL HISTORY

Please ✔ YES or NO to each question. If unsure of a question, please consult with the dentist.

	YES	NO
Do you consider yourself to be in good health? Yes ☐ No ☐		
1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain:	☐	☐
_____ Physician: _____ Phone: _____		
2. Have you ever been hospitalized? _____	☐	☐
3. When was your last visit to a Physician? _____ Last complete physical examination? _____		
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Please list:	☐	☐
1. _____ 2. _____ 3. _____		
4. _____ 5. _____ 6. _____		
5. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Sulfonamide, other antibiotics, ASPIRIN, BARBITURATES (sleeping pills), CODEINE, DARVON, LOCAL ANAESTHETIC (freezing), NITROUS OXIDE, any other medicine: _____	☐	☐

MEDICAL HISTORY CONTINUED ON NEXT PAGE

Last Name:	First	Middle

Medical History continued from previous page.

6. Have you ever been advised against taking any specific type of medication? _____ ☐ ☐
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? _____ ☐ ☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? ☐ ☐
   If so, please explain: _____
9. Has any family member had diabetes? _____ ☐ ☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____ ☐ ☐
11. Do your ankles, feet or hands swell? _____ ☐ ☐
12. Has your weight, appetite or energy level changed dramatically recently? _____ ☐ ☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____ ☐ ☐
14. Do you follow a special diet? _____ ☐ ☐
15. Have you tested positive for any immunocompromising diseases (including HIV, A.I.D.S., Leukemias, etc.?) _____ ☐ ☐
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____ ☐ ☐
17. Have you ever had any injury or surgery to your face or jaws? _____ ☐ ☐
18. Do you wear eyeglasses or contact lenses? _____ ☐ ☐
19. Do you have any hearing difficulties? _____ ☐ ☐
20. Do you smoke or use any other forms of tobacco? _____ ☐ ☐
    Are you wearing the transdermal nicotine patch? _____ ☐ ☐
21. Are you alcohol and/or drug dependent? _____ ☐ ☐
    and, Have you received treatment? _____ ☐ ☐
22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO			
A.I.D.S. or A.I.D.S. related diseases	☐	☐	Head/neck injuries	☐	☐	Malignant Hyperthermia	☐	☐
Anemia	☐	☐	Heart disease or attack	☐	☐	Mental/nervous disorder	☐	☐
Angina pectoris	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse	☐	☐
Arthritis/rheumatism	☐	☐	Heart pacemaker	☐	☐	Organ transplant/medical implant	☐	☐
Artificial heart valve	☐	☐	Heart rhythm disorder	☐	☐	Psychiatric treatment	☐	☐
Artificial joints(hip, knee)	☐	☐	Heart surgery	☐	☐	Radiation treatment/chemotherapy	☐	☐
Blood disorders	☐	☐	Hepatitis A	☐	☐	Rheumatic/Scarlet fever	☐	☐
Bronchitis	☐	☐	Hepatitis B	☐	☐	Sickle cell disease	☐	☐
Cancer	☐	☐	Hepatitis C	☐	☐	Sinus trouble	☐	☐
Circulation problems	☐	☐	Herpes	☐	☐	Stomach/intestinal problems	☐	☐
Congenital heart lesions	☐	☐	High/Low blood pressure	☐	☐	Stroke	☐	☐
Cortisone/steroid	☐	☐	Hodgkins disease	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Hypertension	☐	☐	Ulcers	☐	☐
Epilepsy or seizures	☐	☐	Jaundice	☐	☐	Venereal Disease	☐	☐
Fainting or dizzy spells	☐	☐	Kidney disease	☐	☐	Other _____	☐	☐
Glandular disorders	☐	☐	Liver disease	☐	☐	Other _____	☐	☐
Glaucoma	☐	☐	Lung disease	☐	☐	Other _____	☐	☐

23. Has the CHILD PATIENT recently had any of the following: (indicate approximate date.)
    Measles _____ ☐ ☐
    Mumps _____ ☐ ☐
    Chicken Pox _____ ☐ ☐
    Strep throat _____ ☐ ☐
    Tonsillitis _____ ☐ ☐

24. WOMEN ONLY: Are you pregnant or suspect you may be? _____ ☐ ☐
    If yes, what is the expected delivery date? _____ Are you taking any birth control pills? _____ ☐ ☐

25. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____ ☐ ☐
26. Is there anything else about your health we should be made aware of? _____ ☐ ☐
27. Do you wish to speak to the Doctor privately about any problem or medical condition? _____ ☐ ☐

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in my health status in the future, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by Treating Dentist: _____ Date: _____

MEDICAL HISTORY **MEDICAL HISTORY UPDATES**