# MEDICAL & DENTAL HISTORY Questionnaire

## PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female Birth Date: _____/_____/_____
Last First YYYY MM DD

Name of Family Physician: _____ Physician Phone #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Apartment # Street

_____
City Province Postal Code

## AUTHORITY TO CONSENT FOR A CHILD (if applicable)

Name of person providing medical & dental history information and consent for treatment (please print): _____

Relationship to patient: ☐ Self ☐ Mother ☐ Father ☐ Sibling ☐ Grandparent ☐ Foster parent ☐ Other

Who has custody of the child? ☐ Mother ☐ Father ☐ Shared ☐ Grandparent ☐ CAS ☐ Other

Is custody paper work available? ☐ Yes ☐ No

## PATIENT HEALTH HISTORY

Chief complaint / Reason for this visit: _____

**Has the patient ever had/have any of the following? Please check those that apply:**

- ☐ AIDS/HIV
- ☐ Immune Disorder
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Any Heart Problems
- ☐ Pacemaker
- ☐ Jaundice
- ☐ Anemia
- ☐ Hepatitis
- ☐ Autism
- ☐ Fainting
- ☐ Head injuries
- ☐ Cancer
- ☐ Leukemia
- ☐ Rheumatic Fever
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Nervous disorders
- ☐ Prosthetic Joint
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Physical Delays
- ☐ Malignant Hyperthermia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Convulsions/Epilepsy/ Seizures
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Respiratory Problems
- ☐ Blood Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Mental Delays
- ☐ Frequent Infections
- ☐ ADD / ADHD
- ☐ Eating Disorder
- ☐ Allergies:
  Nickels or Metals ☐ Yes ☐ No
  Foods ☐ Yes ☐ No

Parents/Guardian/Patient Initials: _____

**Have you recently travelled out of Canada? ☐ Yes ☐ No If Yes, where and when?**
_____

**Are you currently feeling unwell with a fever? ☐ Yes ☐ No**

1. Does the patient have or ever had any other health problems/or allergies not listed above? ☐ Yes ☐ No
   If Yes, please explain: _____
2. Is the patient's immunization record up to date? ☐ Yes ☐ No
3. Is the patient currently taking any medication/ non prescription drugs? ☐ Yes ☐ No
   Please list: _____
4. Has the patient ever had an adverse reaction to any medicines / injections? ☐ Yes ☐ No
   If yes, please explain: _____
5. Is the patient being treated for any medical condition at the present or have they been treated in the last year?
   ☐ Yes ☐ No If yes, please explain: _____
6. Was the patient's last medical checkup within the past year? ☐ Yes ☐ No
7. Does the patient have a tendency to bruise easily or bleed for a prolonged period of time? ☐ Yes ☐ No
8. Does the patient: (check if applicable) ☐ Smoke ☐ Consume alcohol ☐ Use recreational drugs

## PATIENT DENTAL HISTORY

1. Has the patient ever been to the dentist? ☐ Yes ☐ No Previous Dentist was: _____

When was the last visit? _____ Were x-rays taken? ☐ Yes ☐ No

When was the last cleaning? _____

2. Has the patient ever had an adverse reaction to dental treatment or anesthetic? ☐ Yes ☐ No

If yes please explain:_____

3. Has the patient ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:_____

4. How often does the patient brush their teeth? ☐ 2-3 times/day ☐ 1 time/day ☐ 1-5/week ☐ never

5. Does the patient use toothpaste that contains fluoride? ☐ Yes ☐ No

6. How often does the patient floss their teeth? ☐ 2-3 times/day ☐ 1 time/day ☐ 1-5/week ☐ never

7. What are typical drinks the patient consumes between meals? _____

8. What type of water does the patient drink? ☐ City water ☐ well water ☐ bottled water ☐ filtered water

9. Does the patient play sports ☐ Yes ☐ No please list: _____

10. Is the patient nervous during dental treatment? Circle NOT AT ALL 1 2 3 4 5 VERY ANXIOUS

If the patient is nervous would you like us to consider additional techniques along with freezing to help?

11. Females only: Are you Pregnant? ☐ Yes ☐ No

For Office Use Only: Additional progress notes ☐ Yes ☐ No

## PARENT/GUARDIAN/EMERGENCY CONTACT INFORMATION

Name of legal guardian: _____ Date of Birth _____/_____/_____
Last First YYYY MM DD

Phone # (Home): _____ (Work): _____ Ext: _____ Cell #:_____

Address: _____
Apt # Street #

_____
City Province Postal Code

**CONSENT:** I acknowledge that the information given above is true to the best of my knowledge and that the questions have been reviewed with me. Should there be any change to the patient health status in the future I will advise the the Family Dental Office staff.

**I acknowledge that I have the authority to consent to treatment on behalf of the above named child (if applicable).** I consent to a patient dental exam which may include some or all of the following: Examination, x-rays, diagnosis, scaling, polishing and topical fluoride as necessary.

I authorize the Family Dental Office to release, to my insuring company plan administrator the claims on my behalf. I understand that by my signature below I am requesting payment be made to the Dentist or Registered Dental Hygienist at the Family Dental Office.

I have been informed that my physician may be contacted by letter, fax or telephone in order to complete details of patient's medical history. I hereby consent to my physician providing the Family Dental Office with any information in this regard which may help ensure safe dental treatment.

_____ _____
Parent / Guardian /.Patient signature Date (yyyy/mm/dd)

_____ _____
RDH Signature Date (yyyy/mm/dd)

_____ _____
Dentist Signature Date (yyyy/mm/dd)

*"The personal information being collected on this form is collected under the authority of the Health Protection and Promotion Act, and is collected, used, and disclosed by the Family Dental Office Staff in accordance with the provisions of the Municipal Freedom of Information and Protection of Privacy Act and the Personal Health Information Protection Act. This information shall be used to ensure necessary health care measures are attained. Questions covering the collection of this information may be directed to the Family Dental Office, 319 Worthington Street East, North Bay, ON, P1B 1H2. Phone (705)474-0655"*

# Informed Consent

The attached treatment plan for _____ has been explained and I have been informed of all procedures, risks, and options for treatment. I understand it is my responsibility to carefully follow the instructions given to me in regard to the treatment.

New patient exams include: examination, radiographs (if necessary), diagnosis, scaling, prophy (as necessary) and fluoride treatment (as necessary).

I understand and agree to have the proposed treatment plan completed at the Family Dental Office. This includes the administration of any local anaesthetic, analgesia or other medication or pharmaceutical agent that may be necessary.

**RISKS FOR TREATMENT INCLUDE:**

**RESTORATIVE:** Infection, damage to adjacent teeth/restorations, pulp exposure, paraesthesia, abscess, gingival/periodontal concerns, failure of restoration.

**EXTRACTION:** Infection, dry socket, nerve damage, damage to adjacent teeth/restorations, mobility of adjacent teeth, soft tissue damage.

**ROOT CANAL TREATMENT:** Infection, nerve damage, failure of root canal, possible need for post/core/crown, possible unrestorability, instrument separation, root fracture, need for extraction, hypochlorite accident.

I understand that dentistry is not an exact science and success cannot be guaranteed. **All risks/complications are avoided and precautions taken however it is necessary that you understand risks associated with each treatment. Any further questions please do not hesitate to ask.**

In the event that the dentist needs to refer me or my child to another dental health professional, I consent to the mutual exchange of pertinent patient information.

I give consent to be reached by the Family Dental Office to confirm appointments by:

| | | |
|---|---|---|
| Phone (voicemail) | YES / NO | |
| Text | YES / NO | Cell phone: _____ |
| E-mail | YES / NO | E-mail: _____ |

_____
Print Name of Parent/Guardian/Patient

_____ _____
Signature of Parent/Guardian/Patient Date (yyyy/mm/dd)

_____
Print Name of Witness

_____ _____
Signature of Witness Date (yyyy/mm/dd)

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