

WELCOME TO OUR DENTAL OFFICE

(For office use only)

Date _____

I.D. #	
MEDICAL ALERT Y <input type="checkbox"/> N <input type="checkbox"/>	

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. **PLEASE PRINT.**

REGISTRATION INFORMATION - This information will enable us to maintain communication with you.

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

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

Prefers to be called: _____ Language Preference: _____

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

Home Phone: () _____ Driver's Lic. No.(If required by office) _____ S.I.N.(If required by office) _____

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

Cell Phone: () _____ Pager No: () _____ E-Mail address: _____

Date of Birth: M ___ D ___ Y ___ Age: _____ Sex: _____ Marital Status: _____ Name of Spouse: _____

Preferred appointment time: _____ Whom may we thank for referring you? _____

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

MEDICAL PRIORITY - This information will enable us to make any essential contacts.

Family Physician: _____ Phone: () _____

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

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

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

Reason for today's visit? Examination Emergency Other _____

Is there a dental problem you would like treated immediately? _____

FINANCIAL INFORMATION - This information is necessary to process invoices and apply payments.

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. (If required by office) _____ S.I.N.(If required by office) _____

METHOD OF PAYMENT (For office use only) CASH CHEQUE CREDIT CARD OTHER

PRIMARY DENTAL INSURANCE (If information required by office) SECONDARY DENTAL INSURANCE

Subscriber's name:		D.O.B.	Subscriber's name:		D.O.B.
Emp./Grp. policy holder:		Ins. yr. end	Emp./Grp. policy holder:		Ins. yr. end
Ins. Co.		Tel.	Ins. Co.		Tel.
Grp./Ind. policy No.		Cert. No.	Grp./Ind. policy No.		Cert. No.
I.D./S.I.N.		Max. Coverage.	I.D./S.I.N.		Max. Coverage.
% coverage: Basic	Maj. Rest.	Ortho.	Other	Other	
% coverage: Basic	Maj. Rest.	Ortho.	Other	Other	

DENTAL HISTORY

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

Is there a dental problem you would like treated immediately? Yes No _____ YES NO

Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____

1. Have you been seeing a dentist regularly? _____
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 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?
 - 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? _____
15. Are you unhappy with the appearance of your teeth? _____
and, What would you like to see changed? _____
16. Do you feel your dental health influences your overall health? _____
17. On a scale of 1 to 10, 10 being highest, how important is it for you to keep your natural teeth? _____

GENERAL RELEASE (Please sign after completing medical questionnaire.)

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 either my health status or any other information I have provided, 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. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. 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: _____

Name: _____	D.O.B. _____	M _____	D _____	Y _____	Patient/Parent/Guardian Initial: _____	Date: _____	M _____	D _____	Y _____
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Please ✓ YES or NO to each question. If unsure of a question, please consult with the dentist. **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: _____ YES NO
2. Have you been hospitalized in the past two years? _____ YES NO
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 incl. herbal remedies
 1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____
5. Have you ever reacted adversely to any medications or injections? (Please circle.) e.g. Penicillin, or other antibiotics aspirin, codeine, local anaesthetic (freezing), nitrous oxide, or any other medicine: _____ YES NO
6. Have you ever been advised against taking any specific type of medication? _____ YES NO
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? _____ YES NO
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: _____ YES NO
9. Is there a family history of Diabetes, Cancer or Heart Disease? _____ YES NO
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____ YES NO
11. Do your ankles, feet or hands swell? _____ YES NO
12. Has your weight, appetite or energy level changed dramatically recently? _____ YES NO
13. Do you follow a special diet, or are you on a diet pill therapy? _____ YES NO
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____ YES NO
15. Have you tested HIV positive? _____ YES NO
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____ YES NO
17. Have you ever had any injury or surgery to your face or jaws? _____ YES NO
18. Do you wear eyeglasses or contact lenses? _____ YES NO
19. Do you have any hearing difficulties? _____ YES NO
20. Do you smoke or use any other forms of tobacco? _____
 Are you wearing the transdermal nicotine patch? _____ YES NO
21. Are you alcohol and/or drug dependent? _____
 and, Have you received treatment? _____ YES NO
22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

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

23. Has the CHILD PATIENT <u>recently</u> had any of the following: (indicate approximate date.)	Measles _____	<input type="checkbox"/>		Mumps _____	<input type="checkbox"/>		Strep throat _____	<input type="checkbox"/>		Chicken Pox _____	<input type="checkbox"/>		Tonsillitis _____	<input type="checkbox"/>	
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24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____ YES NO
25. Is there anything else about your health we should be made aware of? _____ YES NO
26. Do you wish to speak privately to the Doctor about any problem or medical condition? _____ YES NO

27. **Women only:** Are you pregnant or suspect you may be? _____ Expected delivery date? _____ Are you breast feeding? _____
 Are you taking any birth control pills? _____ **Women over 50:** Are you aware of your bone mineral density? _____