PATIENT INFORMATION DATE ___________________

Your cooperation in filling out the data on the confidential 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 unless consent is given otherwise. (Please Print)

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ____
Last First Middle

Age: _____ ☐ Male ☐ Female Birth date: ______________ Home phone: ______________ Cell phone: ______________
Day / Month / Year

Address: ____
Street City Province Postal code

Occupation: ____________________ Employer: ______________________ Bus phone: ______________________

Chose clinic because / referred to clinic by: ☐ Dr. ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Web
☐ Other: _______________ Whom may we thank for referring you? ________________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Dental insurance: ☐ Yes ☐ No Name of Ins. Company: ________________________________
Insurance policy no.: ____________________________ Policy Holder: ________________________________
S.I.N. or Cert. #: ______________________________ Driver's license no.: ____________________________

Person responsible for account: Patient of the practice? ☐ Yes ☐ No

Name: ______________________________ Birth date: __________________ Home phone: __________________
Last First Day / Month/ Year

Address: ____
Street City Province Postal code

MEDICAL HISTORY

Family physician: ______________________ Address: ________________________ Phone: ____________________

In case of emergency notify: Name: ____________________ Relationship: __________ Patient of the practice? ☐ Yes ☐ No

Address: __________________________________ Home phone: ______________ Work phone: ______________

Please answer all questions:

		Yes	No	?
1.	Date of last medical examination: ______________________________			
2.	Are you being treated for any medical condition at the present or been treated within the last year? ……………………….	☐	☐	☐
	If yes, please explain: ____			
3.	Have you been hospitalized in the past 5 years and was surgery performed? …………………………………………………	☐	☐	☐
	If yes, please explain: ____			
4.	Are you presently taking any pills, drugs or medication? (Prescription, non-prescription or herbal) …………………………	☐	☐	☐
	If so please list: 1) ______________ 2) ______________ 3) ______________			
	4) ______________ 5) ______________ 6) ______________			
5.	Have you taken any prolonged medication in the past? (Prescription, non-prescription or herbal) …………………………	☐	☐	☐
	If so please list: 1) ______________ 2) ______________ 3) ______________			
	4) ______________ 5) ______________ 6) ______________			
6.	Do you smoke? ………………………………………………………………………………………………	☐	☐	☐
	If so, how much and for how many years? ______________________________________			
7.	Do you have any allergic condition: i.e. asthma, hay fever, latex or food? …………………………………………………	☐	☐	☐
	If so, please specify: ____			
8.	Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea? ………………………………	☐	☐	☐
	If so, please specify: ____			
9.	Do you ever experience shortness of breath or chest pain when walking or climbing stairs? ………………………………	☐	☐	☐
	If so, please explain: ____			
10.	Do you bruise easily or bleed profusely if cut? ………………………………………………………………	☐	☐	☐
11.	Do your ankles swell during the day? ………………………………………………………………………	☐	☐	☐

Please turn over …

12. Have you ever experienced any unusual reaction to any of the following: Yes No ?

☐ Local anesthesia ☐ Aspirin ☐ Penicillin/Amoxicillin ☐ Erythromycin ☐ Sulfonamide
☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Iodine ☐ Clindamycin ☐ Other

If so, please explain: ____________________

13. Have you been warned about taking any prescription drug or medication? ☐ ☐ ☐

If so, please explain: ____________________

14. Have you ever had radiation treatment or chemotherapy? ☐ ☐ ☐

If so, please explain: ____________________

15. Do you have frequent earaches, ear/throat infections or any hearing difficulties? ☐ ☐ ☐
16. Do you have prosthetic joints? ☐ ☐ ☐
17. Have you ever had a blood transfusion? ☐ ☐ ☐
18. Do you have or have you had any of the following?

☐ Heart murmur/ mitral valve prolapse	☐ Malignant hyperthermia	☐ AIDS or contact	☐ Hepatitis A/B/C	☐ Stomach/intestinal problems
	☐ Drug/alcohol addiction	☐ HIV positive	☐ Liver disease	☐ Cortisone/steroids
☐ Heart attack/trouble	☐ Epilepsy or seizures	☐ Venereal disease	☐ Jaundice	☐ Kidney disease
☐ Stroke / migraines	☐ Mental/nervous disorder	☐ Herpes	☐ Kidney disease	☐ Thyroid problems
☐ Anemia/blood disorder	☐ Hyper (hypo) glycemia	☐ Tuberculosis	☐ Diabetes/family history	☐ Emphysema
☐ High/low blood pressure	☐ Scarlet/rheumatic fever	☐ Arthritis/rheumatism	☐ Organ transplant	☐ Medical implant (pace maker)
☐ Chest pain	☐ Leukemia	☐ Asthma	☐ Ulcers	☐ Sinus problems

Are there other medical conditions? ____________________

FOR WOMEN ONLY:

19. Are you pregnant? If so, what month? ☐ ☐ ☐
20. Are you currently taking birth control pills? ☐ ☐ ☐

DENTAL HISTORY

Previous Dentist: ____________ Address: ____________ Phone: ____________

Yes No ?

1. Are you having any discomforts at this time? ☐ ☐ ☐

   If yes, please explain: ____________________

2. Have you been under regular care by a dentist? ☐ ☐ ☐
3. If yes, when was your last dental visit and what was done? ____________________
4. Why did you decide to change dentist? ____________________
5. Have you ever been given a local anaesthetic (freezing)? ☐ ☐ ☐

   If so, any complications? Please explain: ____________________ ☐ ☐ ☐

6. Have you ever been given general anaesthetic? ☐ ☐ ☐

   If so, any complications? Please explain: ____________________ ☐ ☐ ☐

6. Do you currently experience?

☐ Pain when you chew	☐ Bleeding gums	☐ Loose teeth	☐ Bad breath	☐ Missing teeth
☐ Sensitive teeth (cold/hot)	☐ Neck pain	☐ Lump/swelling in jaw	☐ Earache	☐ Clenching or grinding
☐ Headaches/migraines	☐ Spaced or crooked teeth	☐ Tender/swollen gums	☐ Loose dentures	☐ Jaw joint pain/problems

Are there other dental problems? ____________________

7. Have you been advised to take antibiotics before dental appointments? ☐ ☐ ☐
8. Have you ever experienced any jaw surgery or blows to your jaw? ☐ ☐ ☐
9. Do you have any problems with food packing between your teeth? ☐ ☐ ☐
10. How do you care for your teeth on a daily basis? ☐ Brush, how often? ________ ☐ Floss, how often? ________
11. Is it important for you to keep your natural teeth? ☐ ☐ ☐
12. Are you tense during your dental visits? ☐ ☐ ☐
13. What would you like us to help you with:

☐ Complete Oral Exam	☐ Teeth Cleaning	☐ Teeth Whitening	☐ Cosmetic Dentistry	☐ Orthodontics (Braces)
☐ Dental Implants	☐ Crowns	☐ Dental Extractions	☐ TMJ (joint) pain	☐ Dentures

CONSENT FOR TREATMENT AND OFFICE POLICY

I, the undersigned, acknowledge that I have provided an accurate personal and medical/dental history and to the best of my knowledge, all the preceding answers are true and correct. I will inform you if there are any changes in my health or medications at future appointments. You may contact my physician, if necessary, to discuss any relevant medical information.

I consent to the performing of any dental procedures and x-rays agreed to be necessary or advisable and I will assume any responsibility for fees associated with such procedures. I understand that 48 hours notice must be given if I need to change an appointment, otherwise a fee may be charged.

____________________ Signature of patient / person with legal authority to consent

____________ Date

____________ Dentist