# Welcome To Our Dental Office

| I.D. # | |
|---|---|
| MEDICAL ALERT | Y ◯ N ◉ |

**Date**

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

Name: Dr.☐ Mr.☐ Mrs.☐ Ms.☐ Miss☐

Prefers to be called: Language Preference:

Address:

Home Phone: Bus. Phone: Cell Phone:

Drivers Lic. No. S.I.N (If required by office)

E-mail address: Date of Birth: 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? Y ☐ N ☐ If yes names:

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

Family Physician: Phone:

Medical Specialist: Phone:

In case of emergency, please contact: 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 invoice and apply payments.

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

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

Name: Address:

Home Phone: Bus. Phone: Cell Phone:

Drivers Lic. No. S.I.N

**METHOD OF PAYMENT** (for office use only) **CASH** ☐ **CHEQUE** ☐ **CREDIT CARD** ☐ **OTHER** ☐

**PRIMARY DENTAL INSURANCE** (If irequired by office)

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.

% coverage Basic☐ Maj.Rest.☐ Ortho.☐ Other

**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.

% coverage Basic☐ Maj.Rest.☐ Ortho.☐ Other

# DENTAL HISTORY

**Please Check 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 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? | ☐ | ☐ |
| - Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in on 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 growth or sore spots in your mouth? | ☐ | ☐ |
| 4. Do you 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 you teeth shifted? | ☐ | ☐ |
| 6. Does food catch between your teeth? | ☐ | ☐ |
| 7. Are any of you teen 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? | ☐ | ☐ |
| - 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? | ☐ | ☐ |
| - Mouth breathing while awake or asleep? | ☐ | ☐ |
| - Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? | ☐ | ☐ |
| 13. Do you have any emotion concerns about having dental treatment? | ☐ | ☐ |
| 14. Have you have every had an upsetting experience in a dental office, or any complication 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 you dental health influences your overall health? | ☐ | ☐ |
| 17. On a scale of 1-10, 10 being highest, how important is it for you to keep your natural teeth? | | |

**GENERAL RELEASE (Press sign after completing medial questionnaire.)**

I, the undersigned, certify that I have provided an accurate and complete, personal and medical- dental history and have no 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 my be required to determine necessary. I have been advised of the privacy policy of the office and that determine personal information will be collected, used and disclosed with the guidelines of the policy. I understand that responsibility for payment of the dental service for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

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 |
|---|---|---|---|---|---|---|---|---|---|

Please Check 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:<br>Physician: Phone: | | |
| 2. | Have you been hospitalized in the past two years? | | |
| 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?<br>1. 2. 3.<br>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: | | |
| 6. | Have you been advised against taking any specific medication? | | |
| 7. | Do you have any of the following? Asthma, Hay Fever, Food Allergies, Mental or Latex Allergies, Skin Rashes, Hives, or any other allergic condition? | | |
| 8. | Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: | | |
| 9. | Is there a family history of Diabetes, Cancer, or Heart Disease? | | |
| 10. | Do you bleed EXCESSIVELY from acute 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 following a special diet or are you on a diet pill therapy? | | |
| 14. | Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? | | |
| 15. | Have you tested HIV positive? | | |
| 16. | Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? | | |
| 17. | Have you every 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?<br>Are you wearing the transdermal nicotine patch? | | |
| 21. | Are you alcohol and/or drug dependent?<br>and, Have you received treatment? | | |

**22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A.I.D.S | ☐ | ☐ | Glaucoma | ☐ | ☐ | Lupus | ☐ | ☐ |
| Anemia | ☐ | ☐ | Head/Neck Injuries | ☐ | ☐ | Malignant Hyperthermia | ☐ | ☐ |
| Angina Pectoris | ☐ | ☐ | Heart Disease or Attack | ☐ | ☐ | Mental/nervous disorder | ☐ | ☐ |
| Arthritis/rheumatism | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Mitral valve prolapse | ☐ | ☐ |
| Artificial heart valve | ☐ | ☐ | Heart Pacemaker | ☐ | ☐ | Organ transplant/medical implant | ☐ | ☐ |
| Artificial joints (hip, knee) | ☐ | ☐ | Heart Rhythm Disorder | ☐ | ☐ | Psychiatric Treatment | ☐ | ☐ |
| Blood Disorders | ☐ | ☐ | Heart Surgery | ☐ | ☐ | Radiation treatment/chemotherapy | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | Hepatitis A B C | ☐ | ☐ | Scarlet fever ---Rheumatic fever | ☐ | ☐ |
| Cancer | ☐ | ☐ | Herpes | ☐ | ☐ | Sickle cell disease | ☐ | ☐ |
| Circulation Problems | ☐ | ☐ | High/Low Blood Pressure | ☐ | ☐ | Sinus trouble | ☐ | ☐ |
| Congenital Heart Lesions | ☐ | ☐ | Hodgkin's Disease | ☐ | ☐ | Stomach/intestinal problems/Ulcers | ☐ | ☐ |
| Cortisone/steroid | ☐ | ☐ | Hyper (Hypo) Glycemia | ☐ | ☐ | Stroke | ☐ | ☐ |
| Crohn's Disease | ☐ | ☐ | Hypertension | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Inflammatory Bowel Disease | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Jaundice | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Epilepsy or seizures | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Other | ☐ | ☐ |
| Fainting or dizzy spells | ☐ | ☐ | Liver Disease | ☐ | ☐ | Other | ☐ | ☐ |
| Glandular Disorders | ☐ | ☐ | Lung Disease | ☐ | ☐ | Other | ☐ | ☐ |

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

| | | |
|---|---|---|
| 24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? | ☐ | ☐ |
| 25. Is there anything else about your health we should be made aware of? | ☐ | ☐ |
| 26. Do you wish to speak privately to the Doctor about any problem or medical condition? | ☐ | ☐ |

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?

| Date | Medical Notes | Init. |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: Phone:

Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist: Type:

Are there any changes to your Health History? Yes ☐ No ☐ Please specify:

Women Only: Are you pregnant or suspect you my be? Expecting delivery date? Are you breast feeding?

Are you taking any birth control pills? Woman over 50: Are you aware of you bone mineral density (BMD)?

List all medications currently being used (including herbal remedies): 1. 2.

3. 4. 5. 6.

Date: Reviewed By:

Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: Date

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: Phone:

Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist: Type:

Are there any changes to your Health History? Yes ☐ No ☐ Please specify:

Women Only: Are you pregnant or suspect you my be? Expecting delivery date? Are you breast feeding?

Are you taking any birth control pills? Woman over 50: Are you aware of you bone mineral density (BMD)?

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Date: Reviewed By:

Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: Date

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: Phone:

Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist: Type:

Are there any changes to your Health History? Yes ☐ No ☐ Please specify:

Women Only: Are you pregnant or suspect you my be? Expecting delivery date? Are you breast feeding?

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