WELCOME TO OUR DENTAL OFFICE

(For office use only)

I.D. #	
MEDICAL ALERT Y ☐ N ☐	

Date _____

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: ( ) _____

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

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 - Please complete all information if different than above.

Person responsible for account: Self ☐ Spouse ☐ Other ☐

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

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

Employed by: _____ Phone: ( ) _____

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

Subscriber's name:		D.O.B.		Subscriber's name:		D.O.B.	
Ins. Co.		Tel.		Ins. Co.		Tel.	
Grp. / policy No.	ID / Cert. No.			Grp. / policy No.	ID / Cert. No.		

PATIENT REGISTRATION DENTAL HISTORY

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: _____

FORM: DMDSEL RMSPRDH
custom pedlar REV:6

Name: | D.O.B. | Patient/Parent/Guardian Initial: | Date:

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: _____
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
   1. _____ 2. _____ 3. _____
   4. _____ 5. _____ 6. _____
5. Are you taking Bisphosphonates? If so, for what condition: _____
6. 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: _____
7. Have you ever been advised against taking any specific type of medication? _____
8. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? _____
9. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: _____
10. Is there a family history of Diabetes, Cancer or Heart Disease? _____
11. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____
12. Do your ankles, feet or hands swell? _____
13. Has your weight, appetite or energy level changed dramatically recently? _____
14. Do you follow a special diet, or are you on a diet pill therapy? _____
15. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____
16. Have you tested HIV positive? _____
17. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____
18. Have you ever had any injury or surgery to your face or jaws? _____
19. Do you wear eyeglasses or contact lenses? _____
20. Do you have any hearing difficulties? _____
21. Do you smoke or use any other forms of tobacco? _____
    Are you wearing the transdermal nicotine patch? _____
22. Are you alcohol and/or drug dependent? _____
    and, Have you received treatment? _____
23. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO		YES	NO
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	☐	☐	Hodgkins 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: (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? _____

MEDICAL HISTORY **MEDICAL HISTORY UPDATES**