WELCOME TO OUR DENTAL HOME

(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) _____

Do you prefer us to call you at: Driver's Lic. No. (if req'd by office) _____ S.I.N. (if req'd by office) _____

☐ Home Phone: ( ) _____

☐ Bus. Phone: ( ) _____ Ext. ____ Employer: _____

☐ Cell Phone: ( ) _____ Date of Birth: M____ D____ Y____ Age: ____ Sex: ____ Marital Status: _____

☐ Email Address: _____ 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: ( ) _____

Pharmacy Contact: _____ 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? _____

DENTAL INFORMATION

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

	YES	NO
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 or dentures?	☐	☐
- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of you jaw joints?)	☐	☐
If you answered "yes" to the last question, who performed the surgery? _____ When? _____		
3. Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐	☐
4. Have you been advised to take antibiotics before a dental appointment?	☐	☐
5. Do you have any emotional concerns about having dental treatment?	☐	☐
6. Have you ever had an upsetting experience in a dental office, or any complications during of following dental treatment, or, do you have any questions or concerns?	☐	☐
Would you like whiter teeth?	☐	☐

What do you like most about your smile? _____

What are you looking for to improve your oral health? _____

What do you look for most in a dentist/dental office? _____

DENTAL HISTORY HEALTH HISTORY

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. 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. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? _____ ☐ ☐
7. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: _____ ☐ ☐
8. Is there a family history of Diabetes, Cancer or Heart Disease? _____ ☐ ☐
9. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____ ☐ ☐
10. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____ ☐ ☐
11. Do you smoke or use any other forms of tobacco? _____ ☐ ☐
    Are you wearing the transdermal nicotine patch? _____ ☐ ☐
12. **Women only:** Are you pregnant or suspect you may be? _____ Expected delivery date? _____ Are you breast feeding? _____ ☐ ☐
13. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

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

GENERAL RELEASE

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: dental/health history custom Dr Grover