fairview dentistry

1 - Patient Information

name_____

address_____

_____

phone 1 _____2 _____

male ☐ female ☐ Birthday _____

emerg contact_____

emerg number_____

occupation/school_____

2 - Dental Insurance

who is responsible for this account_____

relationship to patient_____

insured member name_____

members birthday_____

insurance company_____

group number _____

certificate id number _____

I would like my benefits paid direct to the dentist ☐

I would like to pay in full and have my benefits pay me ☐

3 - Medical Priority

family physician_____ phone _____

medical specialist_____ phone_____

nearest relative not living with you_____ phone _____

health card number _____

Hygiene Smile Assessment: On a scale of 1-10 how would you rate your smile?_____ Would you like whiter teeth?_____

If we could straighten your teeth without braces using Invisalign, would you be interested? _____

4 dental history

reason for todays visit _____

_____

former dentist _____

date of last dental visit _____

date of last x-rays_____

place a mark on "yes" or "no" if you have had any of the following:

bad breath yes☐ no☐

bleeding gums yes☐ no☐

blisters on lips or mouth yes☐ no☐

burning sensation on tongue yes☐ no☐

do you use Canabis? If so, what type and how often?

chew on one side yes☐ no☐

tobacco/cannabis smoking yes☐ no☐

clicking or popping jaw yes☐ no☐

dry mouth yes☐ no☐

fingernail biting yes☐ no☐

food collecting between teeth yes☐ no☐

grinding teeth yes☐ no☐

swollen/tender gums yes☐ no☐

jaw pain or tiredness yes☐ no☐

lip or cheek biting yes☐ no☐

loose teeth or fillings yes☐ no☐

mouth breathing yes☐ no☐

mouth pain/brushing yes☐ no☐

orthodontic treatment yes☐ no☐

pain around ear yes☐ no☐

periodontal treatment yes☐ no☐

sensitivity to hot yes☐ no☐

sensitivity to cold yes☐ no☐

sensitivity to sweet yes☐ no☐

sensitivity when you bite yes☐ no☐

sores or growths yes☐ no☐

how often do you brush_____

how often do you floss_____

what type of brush?

5 – Medical Histroy

are you being treated for any medical condition at present or within the past two years? If yes, please explain

_____

when was your last visit to physician_____ have you been hospitalized in the last two years?_____
do you suffer from any form of anxiety?_____have you ever required a prophylactic antibiotic for dental treatment?_____

place a mark in "yes" or "no" to indicate if you've had the following:

A.I.D.S.	yes☐	no☐	glaucoma	yes☐	no☐	lupus	yes☐	no☐
anemia	yes☐	no☐	head/neck injury	yes☐	no☐	malignant hyperthermia	yes☐	no☐
angina pectoris	yes☐	no☐	heart disease/attack	yes☐	no☐	mental/nervous disorder	yes☐	no☐
arthritis	yes☐	no☐	heart murmur	yes☐	no☐	mitral valve disorder	yes☐	no☐
artificial heart valve	yes☐	no☐	heart pacemaker	yes☐	no☐	organ transplant/medical implant	yes☐	no☐
artificial joint	yes☐	no☐	heart rhythm disorder	yes☐	no☐	psychiatric treatment	yes☐	no☐
blood disorders	yes☐	no☐	heart surgery	yes☐	no☐	radiation treatment/chemotherapy	yes☐	no☐
bronchitis	yes☐	no☐	hepatitis A B C	yes☐	no☐	scarlet or rheumatic fever	yes☐	no☐
cancer	yes☐	no☐	herpes	yes☐	no☐	sickle cell disease	yes☐	no☐
circulation problems	yes☐	no☐	high/low blood pressure	yes☐	no☐	sinus trouble	yes☐	no☐
congenital heart problem	yes☐	no☐	hodgkins disease	yes☐	no☐	stomach/intestinal problem/ulcers	yes☐	no☐
cortisone/steroid	yes☐	no☐	hyper/hypo glycemia	yes☐	no☐	stroke	yes☐	no☐
crohn's disease	yes☐	no☐	hypertension	yes☐	no☐	thyroid disease	yes☐	no☐
diabetes	yes☐	no☐	inflammatory bowel	yes☐	no☐	tuberculosis	yes☐	no☐
emphysema	yes☐	no☐	jaundice	yes☐	no☐	venereal disease	yes☐	no☐
epilepsy or seizures	yes☐	no☐	kidney disease	yes☐	no☐	other_____		
fainting or dizzy spells	yes☐	no☐	liver disease	yes☐	no☐	other_____		
glandular disorders	yes☐	no☐	lung disease	yes☐	no☐	other_____		

Women

are you pregnant yes☐ no☐ due date_____ are you nursing yes☐ no☐
taking birth control pills yes☐ no☐

Medications

list any medications you currently taking and the correlating diagnosis below

Allergies

☐aspirin ☐local anesthetic
☐barbiturates ☐penicillin
☐codeine ☐sulpha
☐Iodine ☐other _____
☐ no known drug allergies

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've had the opportunity to ask questions and receive answers to questions regarding my medical/dental history. SHOULD HERE 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 any other health care provider may be necessary. 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.

Name_____ Date _____ Signature _____

☐patient ☐parent ☐guardian