WELCOME TO OUR DENTAL OFFICE

(For office use only)

I.D. #	
MEDICAL ALERT Y ☐ N ☐	

Date_____
M D Y

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.

ADULT PATIENT or (Parent Guardian) REGISTRATION ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Other_____

Are you the: ☐ PATIENT ☐ PARENT ☐ GUARDIAN

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

Address: _____
(street) (city) (prov./state) (postal/zip code)

Date of Birth:_____ Age ____ Sex ____ Marital Status _____ Home Phone: ( ) _____
M D Y

Employer: _____ Phone: ( ) _____ Ext. _____

Referring Dr. _____ Phone: ( )_____

Family Physician _____ Phone: ( )_____

Address: _____
(street) (city) (prov./state) (postal/zip code)

Medical Specialist _____ Phone: ( )_____

CHILD REGISTRATION or ADULT UNDER GUARDIANSHIP

Name: _____ _____
(last) (first) (initial) Prefers to be called

Address: _____
(If different than above) (street) (city) (prov./state) (postal/zip code)

Date of Birth:_____ Age _____ Sex _____ Home Phone: ( )_____
Mo. Day Yr.

School: _____ Grade: _____

Person responsible for account: ☐ Self ☐ Spouse ☐ Other If other, please complete the following:
Method of payment: Cash ☐ Cheque ☐ Credit Card ☐

Name:_____ Home Phone: ( ) _____

Address: _____
(street) (city) (prov./state) (postal/zip code)

Employer: _____ Phone: ( ) _____ Ext. _____

Spouse's name: _____ Occupation: _____

Employer: _____ Phone: ( ) _____ Ext. _____

In case of emergency: _____ Phone: ( ) _____

Closest family relative _____ Phone: ( ) _____

Is another family member or relative a patient at our office?_____

PRIMARY DENTAL INSURANCE				SECONDARY DENTAL INSURANCE			
NAME OF INSURED		DATE OF BIRTH M /D /Y		NAME OF INSURED		DATE OF BIRTH M /D /Y	
EMPLOYER				EMPLOYER			
INSURANCE CARRIER				INSURANCE CARRIER			
GROUP/POLICY NUMBER		DIVISION		GROUP/POLICY NUMBER		DIVISION	
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER		DEPT. NO.	I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER		DEPT. NO.
COVERAGE PERCENTAGE A B C D				COVERAGE PERCENTAGE A B C D			
LIMITS BASIC MAJOR ORTHO				LIMITS BASIC MAJOR ORTHO			
DEDUCTIBLE BASIC MAJOR		☐ PER PERSON ☐ PER FAMILY		DEDUCTIBLE BASIC MAJOR		☐ PER PERSON ☐ PER FAMILY	
SIGNATURE(S) REQUIRED: ☐ PATIENT ☐ INSURED ☐ EMPLOYER SUBMISSION: ☐ CARRIER ☐ PATIENT ☐ EMPLOYER ☐ OTHER				SIGNATURE(S) REQUIRED: ☐ PATIENT ☐ INSURED ☐ EMPLOYER SUBMISSION: ☐ CARRIER ☐ PATIENT ☐ EMPLOYER ☐ OTHER			

(2)

MEDICAL HISTORY

Date _____ (M D Y)

MEDIC ALERT

The following information is required by the dentist to assist in proper diagnosis and treatment. *ALL INFORMATION IS CONFIDENTIAL*

	Yes	Don't Know /Maybe	No
1. Have you ever had a serious illness requiring hospitalization or extensive medical care?	☐	☐	☐
Specify: _____			
2. Are you presently under the care of a physician?	☐	☐	☐
If so, explain: _____			
3. Have you been hospitalized in the last 5 years?	☐	☐	☐
4. Have you had a medical examination in the last year?	☐	☐	☐
5. Do you use any prescription or non-prescription medicine including herbal remedies, regularly?	☐	☐	☐
Specify: _____			
6. Do you have any allergic condition: i.e. asthma, hay fever, skin rash, food allergies, metal or latex allergies?	☐	☐	☐
7. Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea?	☐	☐	☐
Specify: _____			
8. Have you ever experienced any unusual reaction to any of the following? (please circle)	☐	☐	☐
local anaesthesia (freezing), aspirin, penicillin, iodine, sulfonamide, barbiturates (sleeping pills), or any other medicine? If so, explain: _____			
9. Have you been warned against taking any drug or medication?	☐	☐	☐
10. Do you have or have you ever had any of the following? (please check ✓)	☐	☐	☐

☐ Heart murmur or mitral valve prolapse	☐ Malignant hyperthermia	☐ AIDS	☐ Hepatitis A/B/C	☐ Liver disease
☐ Stomach/intestinal problems	☐ Drug/alcohol addiction	☐ Positive testing for HIV virus	☐ Herpes	☐ Cortisone/steroid therapy
☐ Joint replacement (hip, knee, etc.)	☐ Venereal disease		☐ Heart attack	
☐ Mental or nervous disorder	☐ Any lung disease	☐ Jaundice	☐ Cold sores	☐ Other
☐ High/low blood pressure	☐ Thyroid disease	☐ Diabetes	☐ Cancer	_____
☐ Hyper (hypo) glycemia	☐ Arthritis or rheumatism	☐ Tuberculosis	☐ Kidney disease	_____
☐ Epilepsy or seizures	☐ Scarlet or rheumatic fever	☐ Stroke	☐ Sinus trouble	_____

11. Have you ever had any known contact with the AIDS virus?	☐	☐	☐
12. Has any member of your family had diabetes?	☐	☐	☐
13. Do you bruise easily or bleed abnormally?	☐	☐	☐
14. Do your ankles swell during the day?	☐	☐	☐
15. Have you had any weight changes recently?	☐	☐	☐
16. Do you have any blood disorders such as anemia (thin blood), thalassaemia (major, minor)?	☐	☐	☐
17. Have you ever had radiation treatment or chemotherapy?	☐	☐	☐
If so, explain _____			
18. Have you ever had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐	☐
19. Do you have frequent severe headaches?	☐	☐	☐
20. Do you have frequent earaches, ear/throat infections or any hearing difficulties?	☐	☐	☐
21. Is your eyesight: ☐ Good ☐ Adequate ☐ Poor Do you wear contact lenses?	☐	☐	☐
22. Are you on a special diet?	☐	☐	☐
23. Have you ever fainted?	☐	☐	☐
24. Do you ever experience shortness of breath or chest pain when walking or climbing stairs?	☐	☐	☐
If so, explain _____			
25. Have you had any organ transplants or medical implants?	☐	☐	☐
26. Do you have any disease, condition or problem that you think the doctor should know about?	☐	☐	☐
If so, explain _____			
27. Is there anything about yourself that we should be made aware of?	☐	☐	☐
If so, explain _____			
28. WOMEN ONLY - Are you pregnant? If so, which month are you in?	☐	☐	☐
- Are you taking any birth control pills?	☐	☐	☐

TO AVOID COMPLICATIONS, PLEASE NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR MEDICAL CONDITION.

DENTAL HISTORY

Date _____ (M D Y)

MEDIC ALERT

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1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other _____
   Is there a dental problem you would like to have taken care of as soon as possible? _____
2. How frequently do you see your dentist? ☐ 6 Months ☐ Yearly ☐ Other _____
   Former dentist _____ Last dental visit _____
   Last cleaning _____ Last full mouth series of x-rays _____ X-rays requested _____
3. Have you been given oral hygiene instruction in: ☐ Brushing ☐ Flossing ☐ Other _____ By whom? _____
4. Brushing: ☐ Vigorous ☐ Light How often? _____ Type of brush? _____
5. How often do you floss your teeth? _____
6. Other cleaning aids used: ☐ Floss ☐ Stimudents ☐ Toothpick ☐ Other _____
7. Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____
8. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously
9. Is your sugar intake: ☐ High ☐ Medium ☐ Low
10. Have you ever had or do you now have any of the following? (please check (✓)

☐ Bridges	☐ Lost fillings	☐ Bite appliance/night guard	☐ Gum treatments
☐ Partial dentures	☐ Extractions	☐ Swelling or pain in your mouth or jaws	☐ Gag easily
☐ Full dentures	☐ Loose teeth		☐ Difficulty opening or closing your jaw
☐ Root canal fillings	☐ Orthodontic treatment	☐ Injuries to your face or jaws	
☐ Dental implants	☐ Bite adjustment	☐ Surgery in your mouth	

	Yes	Don't Know /Maybe	No
11. Do you chew on only one side of your mouth? If so, why? _____	☐	☐	☐
12. Does any part of your mouth hurt when clenched? _____	☐	☐	☐
13. Does your jaw crack or pop when opened widely? _____	☐	☐	☐
14. Do you have any pain in your ears? _____	☐	☐	☐
15. Have you experienced any growth or sore spots in your mouth? If so, where? _____	☐	☐	☐
16. Do you - grind or clench your teeth during the day or night? _____	☐	☐	☐
- mouth breathe while awake or asleep? _____	☐	☐	☐
- bite your lips or cheeks regularly? _____	☐	☐	☐
- hold any foreign objects with your teeth? (i.e. pipe, pencils, nails) _____	☐	☐	☐
- smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other _____ No. per day _____	☐	☐	☐

17. Check (✓) any of the following you are interested in or you have thought about:

☐ Orthodontics (braces)	☐ Repairing chipped teeth	☐ Improved gum health
☐ Bonding (straightening)	☐ Bleaching (whitening teeth)	☐ Improving your bite
☐ Closing spaces between teeth	☐ Crowns (caps)	☐ Improving breath odor
☐ Replacing missing teeth	☐ Sports mouth guard	☐ Improving your smile

18. Would you rate your current dental health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
19. Do you have any emotional concerns regarding your dental visit? ☐ Fear ☐ Pain ☐ Time ☐ Money
    ☐ Embarrassment ☐ Other concerns _____

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: _____

MEDICAL HISTORY UPDATE

If change, record in medical history.

Date	Same	Change	Patient Signature	Dr. Initials
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____

Date	Same	Change	Patient Signature	Dr. Initials
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____

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