WELCOME TO OUR DENTAL OFFICE

(For Office use only)
ID #
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 collection, using and disclosing this information responsibly.

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) (Appt#) (City) (Province) (Postal Code)

Home Phone: Bus. Phone: Ext Cellphone:

Email: _____ Employer: _____ May we call you at work? _____

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 – This information is necessary to process invoices and apply payments.

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

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

Address: (street) (Appt#) (city) (province) (postal code) Employee:

Method of payment: **CASH** ☐ **CHEQUE** ☐ **CREDIT CARD** ☐ **OTHER** ☐

PRIMARY DENTAL INSURANCE

Subscriber's name: _____ DOB: _____

Insurance Comp: _____

Policy holder: _____ Cert. num: _____

SECONDARY DENTAL INSURANCE

Subscriber's name: _____ DOB: _____

Insurance Comp: _____

Policy holder: _____ Cert num: _____

I authorize release to my benefits plan administrator information contained in claims submitted electronically. Also, I hereby assign my benefits, payable from claims submitted electronically, **to My Smile Dentistry on King and authorize payment directly to them.** This authorization shall continue in effect until the undersigned revokes the same.

Signature: _____

DENTAL HISTORY – Please √ YES or NO to each question. If unsure of a question, please consult with the dentist.

	YES	NO
1. Is there a dental problem you would like treated immediately? If Yes, please explain. _____	☐	☐
2. When was your last dental visit? _____ Last dental Cleaning? _____ Last x-rays? _____		
3. Have you been seeing dentist regularly?	☐	☐
4. Have you ever had any of the following? A. Periodontal treatment (treatment of gums)	☐	☐
B. Orthodontic treatment (to straighten teeth)	☐	☐
C. A bite plane or any other appliance	☐	☐
D. Your bite adjusted or teeth ground	☐	☐
E. Oral surgery (surgery or implant in or about the mouth or jaw joint).....	☐	☐
If you answered yes to last question who performed the surgery and when?_____		
5. Are you being followed up by a dental specialist. If yes, please explain? _____	☐	☐
6. Are there any growths or sore spots in your mouth?	☐	☐
7. Do your gums bleed when brushing or eating or do you suffer from pain/swelling of your gums	☐	☐
8. Have you noticed any loose teeth, or, have any of your teeth shifted	☐	☐
9. Does food catch between your teeth?	☐	☐
10. Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐	☐
11. Have you been advised to take antibiotics before dental appointment?	☐	☐
12. How often do you brush your teeth? _____ Do you feel that you have bad breath?	☐	☐
13. 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?	☐	☐
14. 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)?	☐	☐
15. Do you have any emotional concerns about having dental treatment?	☐	☐
16. Have you ever had any upsetting experience in dental office, or any complications during or after dental treatment, Or, do you have any questions or concerns? If yes, please explain. _____	☐	☐
17. Are you unhappy with the appearance of your teeth?	☐	☐
If yes, what would you like to see changed? _____		
18. Do you feel your dental health influences your overall health?	☐	☐
19. 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.

_____ _____

(signature) Patient ☐ Parent ☐ Guardian ☐ Print name

Reviewed by treating Dentist: _____ Date: _____

Name:	DOB:	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. _____	☐	☐
2. Have you been hospitalized for any illnesses or operations in the past two years? If yes, please explain. _____	☐	☐
3. Has there been any change in your general health in the past year? If yes, please explain. _____	☐	☐
4. When was your last visit to a Physician? _____ Last complete physical examination? _____		
5. Have you recently, or are you presently, taking any **prescription or non-prescription** drugs incl. herbal remedies…. If yes, please list medications. _____	☐	☐
6. Have you ever had a peculiar or adverse reaction to any medications or injections? (Please circle) Penicillin, Clindamycin, Aspirin, Local Anesthetic, Nitrous Oxide or any other medicine:_____	☐	☐
7. Have you ever been advised against taking any specific type of medication? If yes, please explain. _____	☐	☐
8. Do you have any of the following? (Please circle) Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin rashes, Hives or any other Allergic reactions. _____	☐	☐
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 have have or have you ever had any heart or blood pressure problems?	☐	☐
12. Do you have or ever had a replacement/repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?	☐	☐
13. Do you have prosthetic or artificial joint?	☐	☐
14. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, Radiotherapy, chemotherapy)?	☐	☐
15. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	☐	☐
16. Do your ankles, feet or hands swell?	☐	☐
17. Has your weight, appetite or energy level changed dramatically recently?	☐	☐
18. Do you follow a special diet, or are you on diet pill therapy?	☐	☐
19. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
20. Have you or anyone in your family tested HIV positive or have Hepatitis A B or C?	☐	☐
21. Do you have FREQUENT SEVERE headaches, ear aches, ear/throat infections?	☐	☐
22. Have you had any injury or surgery to your face or jaws?	☐	☐
23. Do you wear eyeglasses or contact lenses?	☐	☐
24. Do you have any hearing difficulties?	☐	☐
25. Do you smoke or chew any forms of tobacco? Or, are you wearing a transdermal nicotine patch?	☐	☐
26. Are you alcohol and/or drug dependent? And, have you received treatment?	☐	☐

27. PLEASE ✓ WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

☐ AIDS	☐ Drug/ cannabis use	☐ Herpes	☐ Mental/Nervous disorder
☐ Anemia	☐ Emphysema	☐ High Blood Pressure	☐ Mitral valve prolapse
☐ Angina Pectoris/ Chest Pain	☐ Epilepsy or seizures	☐ Hodgkin's Disease	☐ Organ transplant/medical implant
☐ Arthritis/ Rheumatism	☐ Fainting or dizzy spells	☐ Hypoglycemia	☐ Osteoporosis medications
☐ Artificial Hip(replacement)	☐ Glandular disorders	☐ Hyperglycemia	☐ Radiation/chemotherapy
☐ Artificial Knee(replacement)	☐ Glaucoma	☐ Hypertension	☐ Scarlet/ Rheumatic fever
☐ Blood disorders	☐ Head/Neck injuries	☐ Inflammatory bowel disease	☐ Sickle Cell Disease
☐ Bronchitis	☐ Heart Attack/Disease	☐ Kidney Disease	☐ Sinus Trouble
☐ Cancer	☐ Heart Murmur	☐ Liver disease	☐ Stomach/intestinal problem/ulcer
☐ Congenital heart lesions	☐ Heart Pacemaker	☐ Low Blood Pressure	☐ Stroke ☐ NONE
☐ Cortisone/Steroid therapy	☐ Heart rhythm disorder	☐ Lung Disease	☐ Thyroid disease ☐ Others:
☐ Crohn's disease	☐ Heart Surgery	☐ Lupus	☐ Tuberculosis _____
☐ Diabetes	☐ Hepatitis A B C	☐ Malignant Hyperthermia	☐ Venereal Disease _____

28. Has the CHILD PATIENT recently had any of the following? (indicate approximate date). PLEASE ✓.
☐ Measles _____ ☐ Strep Throat _____
☐ Mumps _____ ☐ Tonsilitis _____
☐ Chicken Pox _____

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

32. **WOMEN ONLY:** Are you pregnant or suspect you may be? _____ Expected delivery date? _____
Are you breastfeeding? _____ Are you taking any birth contol pills?_____
Women over 50: Are you aware of your bone mineral density? _____