Date _____ **PID #** _____ **MEDICAL ALERT Y ☐ N ☐**

WELCOME TO DENTISTRY IN THE HIGHLANDS

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form.

REGISTRATION INFORMATION

The patient is: Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian: _____

Name: Last _____ First _____ Initial _____ Mr.☐ Mrs.☐ Ms.☐ Miss ☐

Address: Street _____ City _____ Province _____ Postal Code _____.

Prefers to be called:_____ Occupation:_____.

Date of Birth: M._____ D._____ Y. _____ Age:_____ Sex: **M F** Marital Status:_____.

Name of Spouse:_____

Are other family members patients at our clinic? Yes ☐ Names: _____.

Home Phone:(____)-_____ Cell Phone:(____)- _____

Bus. Phone:(____)-_____ Ext. _____ Employer:_____ May we call you at work? Yes ☐ No ☐

Whom may we thank for referring you?_____.

Reason for today's visit? Examination ☐ Emergency ☐ Other ☐_____.

Is there a dental problem you would like treated immediately?_____.

FINANCIAL INFORMATION

Person responsible for account: Self ☐ Spouse ☐ Parent ☐ Other ☐

Name: Last _____ First _____ Initial _____ Mr.☐ Mrs.☐ Ms.☐ Miss ☐

Address: Street _____ Apt # _____ City _____ Province _____ Postal Code _____.

(If different from above.)

PRIMARY DENTAL INSURANCE

Subscriber's name:_____ **D.O.B**_____

Emp./Grp. policy holder: _____

Ins. Co. _____ **Phone #**_____

Grp./Ind. policy No. _____ **Cert. No.** _____

SECONDARY DENTAL INSURANCE

Subscriber's name:_____ **D.O.B**_____.

Emp./Grp. policy holder: _____.

Ins. Co. _____ **Phone #**_____.

Grp./Ind. policy No. _____ **Cert. No.** _____.

Family Physician:_____ Phone:(____)-_____.

Medical Specialist:_____ Phone:(____)-_____.

(if presently under care)

In case of emergency, please contact:_____ Phone:(____)-_____.

Nearest relative not living with you: _____ Phone:(____)-_____.

DENTAL HISTORY **Please check YES or NO to each question. If unsure of a question, please consult the dentist.**

Is there a dental problem you would like treated immediately? Yes ☐ No ☐ _____

_____Previous Dentist: _____

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

Hygienist:_____

1. Have you ever had any of the following?

☐ Periodontal Treatment (treatment of 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/both of your jaw joints)?

☐ Dentures (complete or partial plates)?

2. How often do you brush your teeth?_____ Do you feel that you have bad breath? Yes ☐ No ☐

3. Do you use dental floss, proxabrush or stimudents?_____ How often? _____ Yes ☐ No ☐

4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?

_____ Yes ☐ No ☐

5. Does food catch between your teeth? Yes ☐ No ☐

6. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____ Yes ☐ No ☐

7. 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?

☐ Do suffer from frequent headaches?

☐ Difficulty in opening or closing?

☐ Pain when teeth are clenched?

☐ Pain or difficulty when chewing?

8. 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) ?

9. Do you have any emotional concerns about having dental treatment? Yes ☐ No ☐

10. Are you unhappy with the appearance of your teeth? Yes ☐ No ☐

What would you like to see changed? _____

11. 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? _____

_____ Yes ☐ No ☐

HEALTH HISTORY

Please check YES or NO to each question.

1. Are you being treated for any medical condition at present or within the past year?

If yes, please explain: _____ Yes ☐ No ☐

2. Has there been any changes in your general health in the past year? _____

_____ Yes ☐ No ☐

3. When was your last visit to a Physician?_____ Last complete physical examination? _____

4. List any PRESCRIPTION or NON-PRESCRIPTION drugs you are taking or have recently taken (including birth control pills):_____

5. Are you taking any blood thinners or osteoporosis meds like Fosamax? _____ Yes ☐ No ☐

6. Have you ever had any adverse or unusual reaction to any medications or injections? (e.g. penicillin, or other antibiotics, aspirin, codeine, local anaesthetic ("dental freezing")? Please explain:_____

_____ Yes ☐ No ☐

7. Have you ever been advised against taking any specific type of medication?_____

_____ Yes ☐ No ☐

8. Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal allergies)?_____

_____ Yes ☐ No ☐

9. Have you ever fainted during dental or medical treatment?_____ Yes ☐ No ☐

10. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders?

Please explain:_____ Yes ☐ No ☐

11. Are you on cortisone or steroid therapy, or, are you on a diet pill therapy?_____ Yes ☐ No ☐

12. Do you have any artificial joints (e.g. hip, knee)?_____ Yes ☐ No ☐

13. Have you ever been advised to take antibiotics 1 hour before dental treatment?_____ Yes ☐ No ☐

14. Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) or have you ever had Rheumatic Fever?_____ Yes ☐ No ☐

15. Do you have, or have you ever had, any heart or blood pressure problems (heart or stroke)?

Please explain:_____ Yes ☐ No ☐

16. Do you have or have you ever had any chest pain, shortness of breath or any heart palpitation without exertion?_____ Yes ☐ No ☐

17. Are you presently suffering from any infectious diseases?_____ Yes ☐ No ☐

18. Do you have any condition that could affect your immune system (e.g. arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn's disease)? Please specify:_____ Yes ☐ No ☐

19. Have you ever had any cancer (malignant disease), or are you presently undergoing any radiation treatment/chemotherapy?_____ Yes ☐ No ☐

20. Indicate which of the following you presently have, or ever had: **(Please check all that apply)**

☐ **Asthma**	☐ **Epilepsy or Seizures**	☐ **Tuberculosis**	☐ **Glandular Disorders**
☐ **Bronchitis**	☐ **Hepatitis A,B or C**	☐ **Diabetes**	☐ **Organ Transplant/Medical Implant**
☐ **Emphysema**	☐ **Jaundice**	☐ **Kidney Disease**	☐ **Stomach/Intestinal Problems**
☐ **Lung Disease**	☐ **Liver Disease**	☐ **Thyroid Disease**	☐ **Ulcers**

21. Do you, or did you smoke?_____ Do you drink alcoholic beverages on a regular basis?_____.
Use Recreational Drugs?_____

21. WOMEN ONLY: Are you pregnant? **Y N** If so, due date?_____ Are you breast feeding? **Y N**

22. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)?_____ Yes ☐ No ☐

23. Do you currently have, or ever had in the past, any disease, condition or problem not listed above?
_____ Yes ☐ No ☐

24. Have you had any medical problems requiring hospitalization in the past 5 years? _____
_____ Yes ☐ No ☐

25. Is there anything else about your health we should be made aware of; or do you wish to speak to the doctor privately about any problem or medical condition?_____ Yes ☐ No ☐

NOTES:_____
_____
_____

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 my health status in the future, 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, and I consent to the release of this information. 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 of guardian)

Reviewed by Treating Dentist:_____ Date:_____