WELCOME TO OUR DENTAL OFFICE

(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)

Home Phone: ( ) ______ Additional registration information if required by office: ______

Bus. Phone: ( ) ______ Ext. ______ Employer: ______ May we call you at work? ☐

Cell Phone: ( ) ______ Pager No: ( ) ______ E-Mail address: ______

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) (apt.#) (city) (province) (postal code)

Employed by: ______ Phone: ( ) ______

Additional financial information if required by office: ______

METHOD OF PAYMENT (For office use only) CASH ☐ CHEQUE ☐ CREDIT CARD ☐ OTHER ☐

PRIMARY DENTAL INSURANCE (Complete information only if required by office) SECONDARY DENTAL INSURANCE

PRIMARY				SECONDARY			
Subscriber's name:		D.O.B.		Subscriber's name:		D.O.B.	
Emp./Grp. policy holder:		Ins. yr. end		Emp./Grp. policy holder:		Ins. yr. end	
Ins. Co.		Tel.		Ins. Co.		Tel.	
Grp./Ind. policy No.		Cert. No.		Grp./Ind. policy No.		Cert. No.	
I.D.#		Max. Coverage.		I.D.#		Max. Coverage.	
% coverage: Basic	Maj. Rest.	Ortho.	Other / Other	% coverage: Basic	Maj. Rest.	Ortho.	Other / Other

PATIENT REGISTRATION **DENTAL HISTORY**

DENTAL HISTORY

Name ________________________________ Nickname ______________________________ Age ____________
Referred by ___________________________ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _______________________________ How long have you been a patient? _______________ Months/Years
Date of most recent dental exam ______ /______ /______ Date of most recent x-rays _______ /_______ / ______
Date of most recent treatment (other than a cleaning) ______ / ______ / ______
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ________________
2. Have you had an unfavorable dental experience? ________________
3. Have you ever had complications from past dental treatment? ________________
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ________________
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ________________
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ________________

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ________________
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________________
9. Have you ever noticed an unpleasant taste or odor in your mouth? ________________
10. Is there anyone with a history of periodontal disease in your family? ________________
11. Have you ever experienced gum recession? ________________
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ________________
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ________________

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ________________
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ________________
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________________
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ________________
18. Do you have grooves or notches on your teeth near the gum line? ________________
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________________
20. Do you frequently get food caught between any teeth? ________________

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ________________
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ________________
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ________________
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ________________
25. Are your teeth becoming more crooked, crowded, or overlapped? ________________
26. Are your teeth developing spaces or becoming more loose? ________________
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ___
28. Do you place your tongue between your teeth or close your teeth against your tongue? ________________
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________________
30. Do you clench or grind your teeth together in the daytime or make them sore? ________________
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ____
32. Do you wear or have you ever worn a bite appliance? ________________

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ________________
34. Have you ever whitened (bleached) your teeth? ________________
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ________________
36. Have you been disappointed with the appearance of previous dental work? ________________

Patient's Signature ____ Date ______________
Doctor's Signature ____ Date ______________

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MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age _______

Name of Physician/and their specialty ______________________________

Most recent physical examination ____________________ Purpose ____________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury ____
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ____________)
   - latex
   - nuts ____
   - fruit ____
   - other ____
3. heart problems, or cardiac stent within the last six months ____
4. history of infective endocarditis ____
5. artificial heart valve, repaired heart defect (PFO) ____
6. pacemaker or implantable defibrillator ____
7. orthopedic implant (joint replacement) ____
8. rheumatic or scarlet fever ____
9. high or low blood pressure ____
10. a stroke (taking blood thinners) ____
11. anemia or other blood disorder ____
12. prolonged bleeding due to a slight cut (INR > 3.5) ____
13. pneumonia, emphysema, shortness of breath, sarcoidosis ____
14. tuberculosis, measles, chicken pox ____
15. asthma ____
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ____
18. liver disease ____
19. jaundice ____
20. thyroid, parathyroid disease, or calcium deficiency ____
21. hormone deficiency ____
22. high cholesterol or taking statin drugs ____
23. diabetes (HbA1c = _______) ____
24. stomach or duodenal ulcer ____
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ____

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ____
27. arthritis ____
28. autoimmune disease ____ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ____
30. contact lenses ____
31. head or neck injuries ____
32. epilepsy, convulsions (seizures) ____
33. neurologic disorders (ADD/ADHD, prion disease) ____
34. viral infections and cold sores ____
35. any lumps or swelling in the mouth ____
36. hives, skin rash, hay fever ____
37. STI/STD/HPV ____
38. hepatitis (type ____) ____
39. HIV/AIDS ____
40. tumor, abnormal growth ____
41. radiation therapy ____
42. chemotherapy, immunosuppressive medication ____
43. emotional difficulties ____
44. psychiatric treatment ____
45. antidepressant medication ____
46. alcohol/recreational drug use ____

ARE YOU:

47. presently being treated for any other illness ____
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ____
49. taking medication for weight management ____
50. taking dietary supplements ____
51. often exhausted or fatigued ____
52. experiencing frequent headaches ____
53. a smoker, smoked previously or use smokeless tobacco ____
54. considered a touchy/sensitive person ____
55. often unhappy or depressed ____
56. taking birth control pills ____
57. currently pregnant ____
58. diagnosed with a prostate disorder ____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date __________

Doctor's Signature ______________________ Date __________

ASA ______ (1-6)

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