DENTAL OFFICE

PATIENT INFORMATION

Date _____

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

Name ❑ Dr. ❑ Mrs. ❑ Mr. ❑ Ms. _____
Last First Middle

Email _____ Cell Phone _____

Age _____ Sex _____ Marital Status _____

Address _____
Street Apartment Number

_____
City Province *(State)* Postal Code *(Zip)*

Home Phone _____ Date of Birth _____
Day Month Year

Employed by _____ Bus. Phone _____

Dental Insurance? ❑ Yes ❑ No Name of Company _____

Insurance Policy No. _____ % Covered _____

I.D. No. (Group) _____ Drivers License # _____

Whom may we thank for referring you? _____

In case of emergency, please notify: Name _____

Address _____

Relationship _____ Telephone _____

CONFIDENTIAL MEDICAL HISTORY

Physician's Name _____

Address _____ Phone _____

1. Date of last physical examination: _____
2. Are you presently taking any pills, drugs or medication? ❑ Yes ❑ No
   Please specify _____
3. Have you taken any prolonged medication in the past? ❑ Yes ❑ No
   Prescription or non-prescription? _____
   Please specify _____
4. Have you ever been hospitalized and was surgery performed? ❑ Yes ❑ No
   Please specify _____
5. Are your ankles often swollen? ❑ Yes ❑ No
6. Have you gained or lost excessive weight recently? ❑ Yes ❑ No
7. Have you every had radiation or X-ray therapy? ❑ Yes ❑ No

HAVE YOU EVER BEEN TREATED FOR:

❑ Heart Trouble
❑ Abnormal Blood Pressure
___ high ___ low
❑ Hepatitis
❑ AIDS (HIV)
❑ Herpes ___ Oral ___ Genital
❑ Tuberculosis
❑ Drug Reaction or Allergies to:
___ Penicillin
___ Local Anaesthetic
___ Aspirin
___ Codeine
___ Other

❑ Rheumatic Fever
❑ Epilepsy
❑ Diabetes
❑ Abnormal Blood Tendencies
❑ Anaemia
❑ Arthritis or Joint Problems
❑ Breathing Problems
❑ Liver Problems
❑ Stroke
❑ Fainting Spells
❑ Nervous Problems
❑ Allergies to Food
___ Skin Rash ___ Asthma
___ Hayfever ___ Other

❑ Psychiatric Care
❑ Ulcer
❑ Scarlet Fever
❑ Kidney Problems
❑ Sinusitis
❑ Thyroid Problems
❑ Cancer
❑ Cataract Operation
❑ Venereal Disease
___ Syphilis
___ Gonorrhea
❑ Asthma

FOR WOMEN: Are you pregnant? ❑ Yes ❑ No If so, what month? _____

Is there anything that the dentist should know regarding your medical history that has not been mentioned? _____

_____

Date _____ Signature _____

DENTAL HISTORY

1. When was your last dental visit? _____

   Former Dentist _____

2. How often do you have a dental check-up? _____

3. What kind of dental work have you had in the past **(please circle)**

   Cleanings Fillings Caps Bridges Partial or Full Dentures Root Canal

   Orthodontics Periodontal (gum) Treatment Extractions

	Y	N
4. Have you ever had an unfavourable experience at the dentist?	❑	❑
5. Do you have any discomfort in your teeth due to hot, cold. sweets, biting or or chewing pressure?	❑	❑
6. Does food catch between your teeth? _____ If so, where? _____		
7. Do your gums bleed when brushing or flossing?	❑	❑
8. Are you conscious of bad breath or a bad taste in your mouth?	❑	❑
9. Do you favour one side when chewing?	❑	❑
10. Are you unhappy with the appearance of your teeth, bite or smile?	❑	❑
11. Do you consider your teeth beyond repair?	❑	❑
12. Do you ever wake up with a headache or have a tired feeling in your face or jaws?	❑	❑
13. Do your jaw joints pop, click or grate when opening widely?	❑	❑
14. Do you clench or grind your teeth?	❑	❑
15. Have you lost any teeth due to abcess, accident, decay or gum disease? **(please circle)**		
16. Was it ever suggested that it be replaced?	❑	❑
17. Are you anxious to keep your natural teeth?	❑	❑
18. Are you tense during dental visits?	❑	❑
19. Are you interested in a method to calm your nerves?	❑	❑

20. Describe in your own words what you would like done with your teeth.

_____

_____

CONSENT FOR TREATMENT

This is to certify that I consent to the performing of the dental procedures agreed to be necessary and I will assume responsibility for fees associated with those procedures.

_____ _____

Date Signature (Parent or Guardian)

PARENT'S CONSENT FOR CHILDREN UNDER 18

I hereby consent to the performing of the dental and oral surgery procedures necessary or advisable for my children, including the use of local anaesthesia or nitrous oxide.

_____ _____

Date Signature (Parent or Guardian)

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise It will be necessary to charge for the time lost.

Office policy is that services are paid for at each visit as they are performed. However in certain circumstances arrangements for payment may be made by consulting the business assistant.

Please indicate one of the following with a check mark:

1. ❑ I wish to pay each visit as the services are performed.
2. ❑ I wish to know the total fee for all the work to be done, as well as the number of appointments necessary so that I can pay equal portions at each appointment
3. ❑ I wish to discuss special arrangements for payment.