

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

PATIENT NAME (SURNAME, GIVEN): _____

PREFERRED NAME: _____

BIRTHDATE (DD/MM/YY): _____ SEX/GENDER: _____ HEIGHT/WEIGHT: _____

SCHOOL/OCCUPATION: _____

HOME ADDRESS (Nº, STREET, CITY, PROVINCE): _____

POSTAL CODE: _____ HOME PHONE: _____ OTHER PHONE: _____

CONTACT EMAIL: _____

May we leave a voicemail regarding your appointment at these numbers? Yes No

Are you likely to be available on short notice for future appointments or changes? Yes No

We would like to send you email and text communications which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us.

IN CASE OF EMERGENCY NOTIFY: _____

RELATION: _____ PHONE: _____

FAMILY PHYSICIAN: _____ PHONE: _____

NAME OF MEDICAL SPECIALIST: _____ AREA OF SPECIALTY: _____

PHONE OR ADDRESS: _____

NAME OF MEDICAL SPECIALIST: _____ AREA OF SPECIALTY: _____

PHONE OR ADDRESS: _____

PARENT/GUARDIAN/CAREGIVER 1 INFORMATION

NAME (SURNAME, GIVEN): _____

RELATION: _____

ADDRESS (Nº, STREET, CITY, PROVINCE): _____ PHONE: _____

OCCUPATION: _____ WORK PHONE: _____

PARENT/GUARDIAN/CAREGIVER 2 INFORMATION (IF DIFFERENT THAN ABOVE)

NAME (SURNAME, GIVEN): _____

RELATION: _____

ADDRESS (Nº, STREET, CITY, PROVINCE): _____ PHONE: _____

OCCUPATION: _____ WORK PHONE: _____

PATIENT NAME: _____

PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE

(E.G. SCHEDULING APPOINTMENTS)

NAME: _____ RELATION: _____

HOW DID YOU HEAR ABOUT US?

- | | | |
|---|--|--|
| <input type="checkbox"/> Friend | <input type="checkbox"/> Family member | <input type="checkbox"/> Colleague |
| <input type="checkbox"/> Staff member at our office | <input type="checkbox"/> Patient at our office | <input type="checkbox"/> Referral from health professional |
| <input type="checkbox"/> Website/Internet | <input type="checkbox"/> Advertisement | <input type="checkbox"/> Saw sign/Office in person |
| <input type="checkbox"/> Other: _____ | | |

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

Signature PATIENT PARENT GUARDIAN CAREGIVER Date

INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING)

SUBSCRIBER: _____
RELATION: _____
INSURANCE CO: _____
POLICY PLAN #: _____
DIVISION/SECT.#: _____
SUBSCRIBER ID: _____

SUBSCRIBER: (SECONDARY) _____
RELATION: _____
INSURANCE CO: _____
POLICY PLAN #: _____
DIVISION/SECT.#: _____
SUBSCRIBER ID: _____

PATIENT NAME: _____

PATIENT DENTAL HISTORY

- 1. Reason for today's visit: _____

- 2. Do you have a dental problem that needs to be addressed as soon as possible? Yes No
- 3. Have you been visiting the dentist regularly? Yes No
- 4. Last dental visit _____ Cleaning _____ X-rays _____
- 5. How often do you brush your teeth? _____ Floss your teeth? _____
- 6. Do your gums bleed regularly? Yes No
- 7. Are your teeth sensitive to Hot Cold Biting Sweets Sour N/A
- 8. Do you feel any pain in your teeth? Yes No
- 9. Have you ever had any head, neck, or jaw injuries/surgery? Yes No
- 10. Do you have dry mouth or difficulty swallowing? Yes No
- 11. Do you snore or have sleep apnea? Yes No
- 12. Does your jaw crack, click or pop when opened widely? Yes No
- 13. Do you grind or clench your teeth during the day or night? Yes No
- 14. Do you bite your lips/cheeks frequently? Yes No
- 15. Have you ever experienced any growths, lumps or sore spots in your mouth? Yes No
- 16. Have you noticed any loosening/movement of your teeth? Yes No
- 17. Have you had periodontal (gum) treatment? Yes No
- 18. Have you had orthodontic (braces) treatment? Yes No
- 19. Have you ever had treatment by a dental specialist? Yes No
- 20. Have you had previous problems with dental treatment? Yes No
- 21. Are you satisfied with the appearance of your teeth? Yes No
- 22. Are you nervous/anxious/fearful during dental treatment? Yes No
- 23. Please list any other information that you feel we should have to provide you with the best possible dental care:

Signature PATIENT PARENT GUARDIAN CAREGIVER

Date

Reviewed By Dentist

Date

PATIENT NAME: _____

MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

1. Do you have any health problems? Yes No
If yes, please provide details: _____

2. Has there been any change in your general health or weight in the past year? Yes No
If yes, please explain: _____

3. Are you currently being treated for any medical condition or have been treated in the last year? Yes No
If yes, please explain: _____

4. When was the last time you had a medical examination? _____
Were any problems identified? Yes No
If yes, please explain: _____

5. Have you ever been hospitalized for any illnesses or operations? Yes No
If yes, please provide details: _____

6. Are you taking any medications, non-prescription drugs, homeopathic or herbal supplements, or hormones of any kind? Yes No
If yes, please list and provide reason for taking: _____

7. Do you have any allergies or reactions? Yes No
If yes, please list using the categories below:
Medications _____
Latex/rubber derived products _____
Other (e.g. seasonal, foods, dyes) _____
8. Have you had an adverse reaction to any dental materials, injections or local anaesthetic? Yes No
If yes, please explain: _____

9. Do you have or have you ever had a replacement or a 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? Yes No
If yes, please explain: _____

10. Have you been advised to take pre-medication (e.g. antibiotics) prior to dental treatment? Yes No
If yes, please explain: _____
11. Do you have a prosthetic or artificial joint? Yes No
If yes, please provide details: _____

MEDICAL HISTORY CONTINUED ON NEXT PAGE

PATIENT NAME: _____

MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

12. Do you have any conditions or have undergone therapies that could affect your immune system? Yes No
(Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)

If yes, please explain: _____

13. Have you ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders? Yes No

If yes, please explain: _____

14. Do you have a bleeding problem, bleeding disorder, bruising tendency, or have had a blood transfusion? Yes No

If yes, please explain: _____

15. Do you have any or have you ever had any of the following (check all that apply): Yes No

- | | | |
|--|---|---|
| <input type="checkbox"/> Fainting/Dizzy spells | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hyper/Hypoglycemia |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Mental or Nervous disorder |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other communicable disease/
Transmissible infection |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain/Angina/Heart attack |
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Drug/Alcohol/Cannabis use or dependency |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid disease | |

16. Are there any conditions or diseases not listed above that you have or have had? Yes No

If yes, please explain: _____

17. Are there any diseases or medical problems that run in your family? Yes No

(e.g. diabetes, cancer, or heart disease)

18. Do you smoke, vape, use e-cigarettes or chew tobacco products? Yes No

19. Are you pregnant? Yes No

If yes, what is the expected delivery date: _____

20. Are you breastfeeding? Yes No

MEDICAL HISTORY CONTINUED ON NEXT PAGE

PATIENT NAME: _____

MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

21. Do you identify as a person with a disability? Yes No
If yes, please explain: _____

22. Have you recently travelled to areas where endemic diseases are present? Yes No
23. Have you recently experienced any new symptoms such as a cough, fever, chills, vomiting,
diarrhea, rash or other illness since recent travel or otherwise? Yes No
24. Have you had a recent exposure to a communicable infectious disease? Yes No
(e.g. measles, chicken pox or tuberculosis)
25. Have you recently received antimicrobial therapy? Yes No
If so, for what reason? _____

26. Are your immunizations up to date? Yes No
27. Is there any additional information related to your health that has not been addressed above? Yes No
If so, please advise: _____

Signature PATIENT PARENT GUARDIAN CAREGIVER

Date

Reviewed By Dentist

Date