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

DENTAL HISTORY

Please ✔ YES or NO to each question. If unsure of a question, please consult with the dentist.

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

	YES	NO
Date of your last dental visit? ________ Last dental cleaning? ________ Last x-rays? ________		
1. Have you been seeing a dentist regularly? ________	☐	☐
2. Have you ever had any of the following?		
- Periodontal Treatment? (treatment of the 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 or both of your jaw joints?)	☐	☐
If you answered "yes" to the last question, who performed the surgery? ________ When? ________		
Are you being followed up by a dental specialist? ________	☐	☐
3. Are there any growths or sore spots in your mouth? ________	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? ________	☐	☐
5. Have you noticed any loose teeth, or, have any of your teeth shifted? ________	☐	☐
6. Does food catch between your teeth? ________	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? ________	☐	☐
8. Have you been advised to take antibiotics before a dental appointment? ________	☐	☐
9. Do you use dental floss, proxabrush or stimudents? How often? ________	☐	☐
10. How often do you brush your teeth? ________ Do you feel that you have bad breath? ________	☐	☐
11. 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? ________	☐	☐
- Pain or difficulty while chewing? ________	☐	☐
12. 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)? ________	☐	☐
13. Do you have any emotional concerns about having dental treatment? ________	☐	☐
14. 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? ________	☐	☐
15. Are you unhappy with the appearance of your teeth? ________	☐	☐
and, What would you like to see changed? ________		
16. Do you feel your dental health influences your overall health? ________	☐	☐
17. 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.

X ______________________ ______________________

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by Treating Dentist: ______________________ Date: ____________

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FORM: RMSPRDHC REV:7

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Name:	D.O.B.				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: ☐ ☐
   ______ Physician: ______ Phone: ______
2. Have you been hospitalized in the past two years? ______ ☐ ☐
3. When was your last visit to a Physician? ______ Last complete physical examination? ______
4. Have you recently, or are you presently, taking any **prescription** or **non-prescription** drugs incl. herbal remedies ☐ ☐
   1. ______ 2. ______ 3. ______
   4. ______ 5. ______ 6. ______
5. Have you ever reacted adversely to any medications or injections? (Please circle.) e.g.Penicillin, or other antibiotics aspirin, codeine, local anaesthetic (freezing), nitrous oxide, or any other medicine: ______ ☐ ☐
6. Have you ever been advised against taking any specific type of medication? ______ ☐ ☐
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? ______ ☐ ☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: ______ ☐ ☐
9. Is there a family history of Diabetes, Cancer or Heart Disease? ______ ☐ ☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? ______ ☐ ☐
11. Do your ankles, feet or hands swell? ______ ☐ ☐
12. Has your weight, appetite or energy level changed dramatically recently? ______ ☐ ☐
13. Do you follow a special diet, or are you on a diet pill therapy? ______ ☐ ☐
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ______ ☐ ☐
15. Have you or anyone in your family tested HIV positive or have Hepatitis A B C? ______ ☐ ☐
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? ______ ☐ ☐
17. Have you ever had any injury or surgery to your face or jaws? ______ ☐ ☐
18. Do you wear eyeglasses or contact lenses? ______ ☐ ☐
19. Do you have any hearing difficulties? ______ ☐ ☐
20. Do you smoke or use any other forms of tobacco? ______ ☐ ☐
    Are you wearing the transdermal nicotine patch? ______ ☐ ☐
21. Are you alcohol and/or drug dependent? ______ ☐ ☐
    and, Have you received treatment? ______ ☐ ☐
22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO		YES	NO
A.I.D.S.	☐	☐	Glaucoma	☐	☐	Lupus	☐	☐
Anemia	☐	☐	Head/neck injuries	☐	☐	Malignant Hyperthermia	☐	☐
Angina pectoris	☐	☐	Heart disease or attack	☐	☐	Mental/nervous disorder	☐	☐
Arthritis/rheumatism	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart pacemaker	☐	☐	Organ transplant/medical implant	☐	☐
Artificial joints(hip, knee)	☐	☐	Heart rhythm disorder	☐	☐	Psychiatric treatment	☐	☐
Blood disorders	☐	☐	Heart surgery	☐	☐	Radiation treatment/chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis A B C ______	☐	☐	Scarlet fever ⟶ Rheumatic fever	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Sickle cell disease	☐	☐
Circulation problems	☐	☐	High/Low blood pressure	☐	☐	Sinus trouble	☐	☐
Congenital heart lesions	☐	☐	Hodgkins disease	☐	☐	Stomach/intestinal problems/Ulcers	☐	☐
Cortisone/steroid	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Stroke	☐	☐
Crohn's disease	☐	☐	Hypertension	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Inflammatory bowel disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Jaundice	☐	☐	Venereal Disease	☐	☐
Epilepsy or seizures	☐	☐	Kidney disease	☐	☐	Other ______		
Fainting or dizzy spells	☐	☐	Liver disease	☐	☐	Other ______		
Glandular disorders	☐	☐	Lung disease	☐	☐	Other ______		

23. Has the CHILD PATIENT <u>recently</u> had any of the following: (indicate approximate date.)

	YES	NO		YES	NO
Measles ______	☐	☐			
Mumps ______	☐	☐	Strep throat ______	☐	☐
Chicken Pox ______	☐	☐	Tonsillitis ______	☐	☐

24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? ______ ☐ ☐
25. Is there anything else about your health we should be made aware of? ______ ☐ ☐
26. Do you wish to speak privately to the Doctor about any problem or medical condition? ______ ☐ ☐
27. **Women only:** Are you pregnant or suspect you may be? ____ Expected delivery date? ____ Are you breast feeding? ____
    Are you taking any birth control pills? ____ **Women over 50:** Are you aware of your bone mineral density? ____

Date	MEDICAL NOTES	Init.

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ____________ Phone: ____________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist: ____________ Type: ____________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________

WOMEN ONLY: Are you pregnant or suspect you may be? ______ Expected delivery date? ______ Are you breast feeding? ______
Are you taking any birth control pills? ______ WOMEN OVER 50: Are you aware of your bone mineral density (BMD)? ______
List all medications currently being used (including herbal remedies): 1. ____________ 2. ____________
3. ____________ 4. ____________ 5. ____________ 6. ____________
____________ Date: ______ Reviewed by: ____________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______ Date: ______

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ____________ Phone: ____________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist: ____________ Type: ____________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________

WOMEN ONLY: Are you pregnant or suspect you may be? ______ Expected delivery date? ______ Are you breast feeding? ______
Are you taking any birth control pills? ______ WOMEN OVER 50: Are you aware of your bone mineral density (BMD)? ______
List all medications currently being used (including herbal remedies): 1. ____________ 2. ____________
3. ____________ 4. ____________ 5. ____________ 6. ____________
____________ Date: ______ Reviewed by: ____________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______ Date: ______

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ____________ Phone: ____________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist: ____________ Type: ____________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________

WOMEN ONLY: Are you pregnant or suspect you may be? ______ Expected delivery date? ______ Are you breast feeding? ______
Are you taking any birth control pills? ______ WOMEN OVER 50: Are you aware of your bone mineral density (BMD)? ______
List all medications currently being used (including herbal remedies): 1. ____________ 2. ____________
3. ____________ 4. ____________ 5. ____________ 6. ____________
____________ Date: ______ Reviewed by: ____________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______ Date: ______

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ____________ Phone: ____________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist: ____________ Type: ____________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________

WOMEN ONLY: Are you pregnant or suspect you may be? ______ Expected delivery date? ______ Are you breast feeding? ______
Are you taking any birth control pills? ______ WOMEN OVER 50: Are you aware of your bone mineral density (BMD)? ______
List all medications currently being used (including herbal remedies): 1. ____________ 2. ____________
3. ____________ 4. ____________ 5. ____________ 6. ____________
____________ Date: ______ Reviewed by: ____________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______ Date: ______

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FORM: RMSMHUC
REV:10

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