ID #: ____________________ MEDICAL ALERT: ____________
For Office Use Only

WELCOME TO OUR DENTAL OFFICE

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.

Date: ______/______/__________ (MM DD YYYY) Our receptionist is available to assist you with the completion of this form. Please Print

REGISTRATION INFORMATION

The patient is: ☐ Adult ☐ Child ☐ Adult under Guardianship Name of Guardian: ______________________

Name: ______________________ ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss

Address: ______________________ (Street, Apt/Unit, City, Province, Postal Code) Email: ______________________

Home Phone: (____) ____________ Business Phone: (____) ____________ Ext: ______ Mobile: (____) ____________

Employer: ______________________ May we contact you at work? ☐ Yes ☐ No

PERSONAL INFORMATION

Prefers to be called: ______________________ Occupation: ______________________

Date of Birth: ______/______/__________ (MM DD YYYY) Age: __________ Sex: __________ Pronouns: ______________________

Marital Status: ______________ Name of Spouse: ______________________ Are other family members patients at our office? ☐ Yes ☐ No

Whom may we thank for referring you? ______________________

MEDICAL PRIORITY

Family Physician: ______________________ Phone: (____) ____________

Medical Specialist: ______________________ Phone: (____) ____________
(if presently under care)

In case of emergency, please contact: ______________________ Phone: (____) ____________

FINANCIAL INFORMATION

☐ ***Please check if information same as above***

Person responsible for account: ☐ Self ☐ Spouse ☐ Other

Name: ______________________ Phone: (____) ____________

Address ______________________
(Street, Apt/Unit, City, Province, Postal Code)

Employed by: ______________________ Phone: (____) ____________

Driver's Licence #: ______________________ SIN: ______________________

DENTAL INSURANCE (if information available)

PRIMARY Name of Policy Holder: ______________________ Date of Birth: ______/______/__________ (MM DD YYYY)

Employer/Group Policy Holder: ______________________ Insurance Year End: ______________

Insurance Company: ______________________ Phone: (____) ____________

Group/Individual Policy #: ______________ Certificate #: ______________ ID/SIN: ______________

Maximum Coverage: ______________ Percentage Coverage: Basic ______ Maj. Rest ________ Ortho. ________

SECONDARY Name of Policy Holder: ______________________ Date of Birth: ______/______/__________ (MM DD YYYY)

Employer/Group Policy Holder: ______________________ Insurance Year End: ______________

Insurance Company: ______________________ Phone: (____) ____________

Group/Individual Policy #: ______________ Certificate #: ______________ ID/SIN: ______________

Maximum Coverage: ______________ Percentage Coverage: Basic ______ Maj. Rest ________ Ortho. ________

PREFERRED METHOD OF PAYMENT

☐ Cash ☐ Cheque ☐ Credit Card ☐ Debit ☐ e-Transfer ☐ Other ______________________

HEALTH HISTORY

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes, please explain ____________________
   Physician ____________________ Phone (____)____________________
2. Have you been hospitalized in the past two years? ☐ Yes ☐ No
3. When was your last complete physical examination? ____________________
4. Have you recently or are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? ☐ Yes ☐ No
5. Have you ever reacted adversely to any of the following? ☐ Yes ☐ No
   ☐ Antibiotics (Penicillin, Sulfonamide, other antibiotics) ☐ Aspirin ☐ Barbiturates (sleeping pills) ☐ Codeine
   ☐ Local Anaesthetic (freezing) ☐ Nitrous Oxide ☐ Other medicine ____________________
6. Have you ever been advised against taking any specific type of medicine? ☐ Yes ☐ No
   If yes, please explain ____________________
7. Do you have any of the following? ☐ Yes ☐ No
   ☐ Asthma ☐ Hay Fever ☐ Food Allergies ☐ Metal or Latex Allergies ☐ Skin Rashes ☐ Hives
   ☐ Other allergic condition ____________________
8. Has any family member had diabetes? ☐ Yes ☐ No
9. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? ☐ Yes ☐ No
10. Do your ankles, feet or hands swell? ☐ Yes ☐ No
11. Has your weight, appetite or energy level changed dramatically recently? ☐ Yes ☐ No
12. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ☐ Yes ☐ No
13. Do you follow a special diet? ☐ Yes ☐ No
14. Do you have FREQUENT SEVERE headaches, ear/throat infections? ☐ Yes ☐ No
15. Have you ever had an injury or surgery to your face or jaws? ☐ Yes ☐ No
16. Do you wear eyeglasses or contact lenses? ☐ Yes ☐ No
17. Do you have any hearing difficulties? ☐ Yes ☐ No
18. Do you smoke, use other forms of tobacco, or use marijuana? ☐ Yes ☐ No
19. Are you alcohol and/or drug dependent? ☐ Yes ☐ No
    If yes, have you received treatment? ☐ Yes ☐ No

20. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

- Anemia ☐ Yes ☐ No
- Angina pectoris ☐ Yes ☐ No
- Anxiety and depression ☐ Yes ☐ No
- Arthritis/rheumatism ☐ Yes ☐ No
- Artificial heart valve ☐ Yes ☐ No
- Artificial joints (hip, knee) ☐ Yes ☐ No
- Blood disorders ☐ Yes ☐ No
- Bronchitis ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Circulation problems ☐ Yes ☐ No
- Cold sores ☐ Yes ☐ No
- Congenital heart lesions ☐ Yes ☐ No
- Cortisone/steroid ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No
- Epilepsy or seizures ☐ Yes ☐ No
- Fainting or dizzy spells ☐ Yes ☐ No
- Glandular disorders ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No
- Head/Neck injuries ☐ Yes ☐ No
- Heart disease or attack ☐ Yes ☐ No
- Heart murmur ☐ Yes ☐ No
- Heart pacemaker ☐ Yes ☐ No
- Heart surgery ☐ Yes ☐ No
- Hepatitis A ☐ Yes ☐ No
- Hepatitis B ☐ Yes ☐ No
- Hepatitis C ☐ Yes ☐ No
- High/low blood pressure ☐ Yes ☐ No
- H.I.V+ ☐ Yes ☐ No
- Hodgkins disease ☐ Yes ☐ No
- Hyper (Hypo) glycemia ☐ Yes ☐ No
- Hypertension ☐ Yes ☐ No
- Jaundice ☐ Yes ☐ No
- Kidney disease ☐ Yes ☐ No
- Liver disease ☐ Yes ☐ No
- Lung disease ☐ Yes ☐ No
- Malignant hyperthermia ☐ Yes ☐ No
- Mental health issues ☐ Yes ☐ No
- Mitral valve prolapse ☐ Yes ☐ No
- Organ transplant/ medical implant ☐ Yes ☐ No
- Psychiatric treatment ☐ Yes ☐ No
- Radiation treatment/ chemotherapy ☐ Yes ☐ No
- Rheumatic/scarlett fever ☐ Yes ☐ No
- Sickle cell disease ☐ Yes ☐ No
- Sinus trouble ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Thyroid disease ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Ulcers ☐ Yes ☐ No
- Other ____________________
- Other ____________________

21. WOMAN ONLY: i) Are you pregnant or suspect you may be? . . . . . . ☐ Yes ☐ No If yes, what month? __________
ii) Are you taking birth control pills? . . . . ☐ Yes ☐ No

22. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? ☐ Yes ☐ No
23. Is there anything else about your health we should be made aware of? . . . . ☐ Yes ☐ No
24. Do you wish to speak privately to the Doctor about any problem or medical condition? . . . . ☐ Yes ☐ No

DENTAL HISTORY

1. How frequently do you see your dentist? ☐ 6 months ☐ yearly ☐ other ___________________________
   Last dental visit:______________ Last cleaning:______________ Last full mouth series of x-rays: ____________________
2. Rate your current dental health: ☐ good ☐ fair ☐ poor Is your sugar intake: ☐ high ☐ medium ☐ low
3. Brushing: ☐ vigorous ☐ light How often? ___________________________
4. Cleaning Aids: ☐ floss ☐ Stimudents ☐ toothpicks ☐ other ___________________________
5. Is there a dental concern you would like to have taken care of as soon as possible? . . . . ☐ Yes ☐ No
   If yes, please explain: ___________________________
6. Have you been given oral hygiene instruction any of the following? . . . . ☐ Yes ☐ No
   ☐ brushing ☐ flossing ☐ other ___________________________
7. Does food tend to get caught between your teeth? . . . . ☐ Yes ☐ No
8. Are your teeth sensitive to any of the following? . . . . ☐ Yes ☐ No
   ☐ cold ☐ sweets ☐ heat ☐ pressure ☐ other ___________________________
9. Do your gums bleed? . . . . ☐ Yes ☐ No
   ☐ brushing ☐ flossing ☐ spontaneously ☐ eating/chewing
10. Have you ever had any of the following? . . . . ☐ Yes ☐ No
    ☐ oral surgery ☐ periodontal treatment ☐ orthodontic treatment ☐ bite adjustment ☐ bite plate
    ☐ other appliance Please explain ___________________________
11. Do you have any dental implants? . . . . ☐ Yes ☐ No
12. Do you suffer from pain and/or swelling of your gums? . . . . ☐ Yes ☐ No
13. Are you aware of any loose teeth? . . . . ☐ Yes ☐ No
    If yes, please explain where ___________________________
14. Do you chew on only one side of your mouth? . . . . ☐ Yes ☐ No
    If yes, please explain ___________________________
15. Do you have any of the following habits? . . . . ☐ Yes ☐ No
    ☐ grind or clench your teeth during the day or night? ☐ mouth breathe while awake or asleep?
    ☐ bite your lips or cheeks regularly ☐ hold any foreign objects with your teeth? (i.e. pipe, pencils, finger nail, pins)
16. Does any part of your mouth hurt when clenched? . . . . ☐ Yes ☐ No
17. Do you have any difficulty in opening or closing your jaw wide . . . . ☐ Yes ☐ No
18. Does your jaw crack or pop when opened widely? . . . . ☐ Yes ☐ No
19. Do you have any pain in your ears? . . . . ☐ Yes ☐ No
20. Do you gag easily? . . . . ☐ Yes ☐ No
21. Have you experienced any growths or sore spots in your mouth? . . . . ☐ Yes ☐ No
    If yes, please explain where ___________________________
22. Are you concerned about the appearance of your teeth? . . . . ☐ Yes ☐ No
    If yes, what would you like to change? ___________________________
23. Do you have any concerns regarding your dental visit? . . . . ☐ Yes ☐ No
    ☐ fear ☐ pain ☐ time ☐ money ☐ embarrassment ☐ other ___________________________

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INFORMED CONSENT

GENERAL CONSENT FOR TREATMENT

The undersigned hereby authorizes the doctor or hygienist to take x-rays, study models, photgraphs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

I authorize the doctor or hygienist to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk.

I understand that my Dental Insurance is a contract between me and the Insurance Carrier, and not between the Insurance Carrier and the Doctor. I am fully responsible for all dental fees.

These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I further understand a late charge will be added to any overdue balance and a $20.00 charge will be applied to any cheques returned from the bank. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if l have paid the dental fees incurred.

We strive to be courteous and provide each patient with the best possible service. We ask that you extend this courtesy and provide a minimum of 24 BUSINESS HOURS notice if an appointment that is reserved for you must be cancelled or rescheduled. This crucial to allow us to appoint other patients; specifically those who may be suffering and in pain. If less than 24 BUSINESS HOURS notice is given or you do not show up for your scheduled appointment a fee will be assessed.

Patient Name:______________________________ Patient Signature:______________________________

Witness Name:______________________________ Witness Signature:______________________________

Date:______________________________

I understand the recommended treatment for my conditions, the risks of such treatment and alternatives, as well as the consequences of doing nothing will be explained. Any fee(s) involved will be explained as requested. All my questions have been answered to the best of the staff’s ability. Further, due to the nature of dental treatment, I understand it is impossible to offer any guarantees.

Patient Name:______________________________ Patient Signature:______________________________

Witness Name:______________________________ Witness Signature:______________________________

Date:______________________________