Patient Information and Medical History Questionnaire

Mr. / Miss / Mrs. / Ms. / Dr.
Name: ____
Name of Guardian**:** ______________________________

Date of Birth (Day/Month/Year):______/______/______
Address:
____
____

Phone: (Home #) _______________________
(Cell #)_______________________
Email: __________________________________
Employer: ______________________________________
Phone: _________________________ Ext.______
Occupation: ____________________________________

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:
Name: _______________________________________
Relationship: _______________________
Day-Time Phone: _________________________
Name of Family Doctor: _________________________
Phone or Address: _______________________________
____

Dental Insurance: YES ___ NO ___
Group Policy # ______________________________
Certificate # ________________________________
Insurance Company: ___________________________
Secondary Insurance: YES ___ NO ___
Group Policy # ______________________________
Certificate # ________________________________
Insurance Company: ___________________________
Spouse Employed by: __________________________

Person responsible for Account
SELF ___ OTHER ___ Name: ______________________
Address: _____________________________________
Phone: _____________________________
Email: ______________________________

Who may we thank for referring you to our office?
____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form. Thank you.

Patient Information and Medical History Questionnaire

Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain.

☐ Yes ☐ No ☐ Not sure/Maybe
____
____

When was your last medical check-up?
____

Has there been any changes in your general health in the past year? If yes, please explain.
☐ Yes ☐ No ☐ Not sure/Maybe

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them <u>with dosage and when medication taken.</u>
☐ Yes ☐ No ☐ Not sure/Maybe
____
____

Do you have any allergies? If yes, please list them using the categories below:
☐ Yes ☐ No ☐ Not sure/Maybe

a) Medications ______________________________
b) Latex/rubber products _____________________
c) other (e.g. hay fever, seasonal/environmental, food)
____
____

Have you ever had a peculiar or adverse reaction to any medication or injections? If yes, please explain.
☐ Yes ☐ No ☐ Not sure/Maybe
____
____

Do you have or have you ever had asthma?
☐ Yes ☐ No ☐ Not sure/Maybe

Do you have or have you ever had any heart or blood pressure problems?

☐ Yes ☐ No ☐ Not sure/Maybe

Do you have or have you ever had a replacement or 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 ☐ Not sure/Maybe

PLEASE SEE OVER

Do you have a prosthetic or artificial joint?
☐ Yes ☐ No ☐ Not sure/Maybe

Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?
☐ Yes ☐ No ☐ Not sure/Maybe

Have you ever had hepatitis, jaundice or liver disease?
☐ Yes ☐ No ☐ Not sure/Maybe

Do you have a bleeding problem or bleeding disorder?
☐ Yes ☐ No ☐ Not sure/Maybe

Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ Yes ☐ No ☐ Not sure/Maybe

____

Have you been in contact with any confirmed COVID-19 positive patients?
☐ Yes ☐ No ☐ Not sure/Maybe
If yes, when ______________________________

Have you tested positive with COVID-19?

If YES, when? ______________________________
☐ Yes ☐ No

____

Do you have or have you ever had any of the following? Please check.
__chest pain, angina __heart attack __stroke, TIA
__heart murmur __rheumatic fever __tuberculosis
__mitral valve prolapse __cancer __pacemaker
__lung disease __stomach ulcers __arthritis
__steroid therapy __diabetes __thyroid disease
__drug/alcohol/cannabis use or dependency
__seizures (epilepsy) __kidney disease __shortness of breath __osteoporosis medications (e.g. Fosamax, Actonel)
Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
☐ Yes ☐ No ☐ Not sure/Maybe

____

____
Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)?
☐ Yes ☐ No ☐ Not sure/Maybe

Do you use cannabis? And when did you last use cannabis? If yes for what purpose?
☐ Yes ☐ No ☐ Not sure/Maybe
☐ Medicinal ☐ Recreational ☐ or Both

____

Do you smoke or chew tobacco products?

☐ Yes ☐ No ☐ Not sure/Maybe

Are you nervous during dental treatment?

☐ Yes ☐ No ☐ Not sure/Maybe

Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

☐ Yes ☐ No ☐ Not sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature:

____

Date: ______________________________

SIGN BELOW IF YOU HAVE INSURANCE:

CDAnet

I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.

____
Signature of patient or parent/guardian

Date: ________________ Patient I.D. # ________________

Dentist's Notes:

____

____

____

Dentist's Signature:

____

Date: ______________________________

PAST DENTAL HISTORY

SHADED AREAS - OFFICE USE ONLY

MEDICAL ALERT	CONDITION	PREMEDICATION	ALLERGIES	ANAEST.

PATIENT NAME:	CHART NO:	DATE:

REASON FOR INITIAL VISIT:

LAST DENTAL VISIT: Date: \ \ (M D Y)	LAST DENTAL CLEANING: Date: \ \ (M D Y)	PREVIOUS DENTIST:

Please check YES or NO. *If not sure*, please check NS.

	NO	NS	YES		NO	NS	YES
Are you suffering from pain now?	☐	☐	☐	**ORAL HYGIENE**			
Are any of your teeth becoming loose?	☐	☐	☐	Do you use Dental aids?	☐	☐	☐
Have any of your teeth shifted?	☐	☐	☐	Do you use any fluoride/mouth rinses?	☐	☐	☐
Does food get caught between your teeth?	☐	☐	☐	Are you happy with appearance of your teeth?	☐	☐	☐
Are any teeth sensitive to: cold☐ hot☐ biting☐ pressure☐ sweet☐ bitter☐				What would you like to change about your teeth?			
Is there any swelling or pain of your gums?	☐	☐	☐	How often do you brush your teeth?			
Is there a history of gum disease in your family?	☐	☐	☐	How often do you floss your teeth?			
Are you aware of sores/growths in your mouth?	☐	☐	☐				
Do you notice any bleeding from your gums when you brush your teeth, or other?	☐	☐	☐	**JAW PROBLEMS** Do you have any of the following?	NO	NS	YES
Have you had a local anaesthetic (freezing)?	☐	☐	☐	Clicking/popping of jaw when opening/closing?	☐	☐	☐
....any complications?	☐	☐	☐	Pain (in jaw joints - ear, side of face)?	☐	☐	☐
Have you had any teeth extracted?	☐	☐	☐	Difficulty in opening or closing your mouth?	☐	☐	☐
....any complications?	☐	☐	☐	Pain and/or difficulty in chewing?	☐	☐	☐
Do you have burning sensation of lips or tongue?	☐	☐	☐	Pain when cleaning your teeth?	☐	☐	☐
Does your mouth tend to get dry?	☐	☐	☐	Have you ever had implant surgery in one or both of your jaw joints?	☐	☐	☐
Do you have bad taste in your mouth or bad breath?	☐	☐	☐				
Are you nervous about having dental treatment?	☐	☐	☐	If yes, who performed the surgery and when was it done? ______			
Have you ever had an upsetting experience in a Dental office?	☐	☐	☐				
EXPLAIN:				Are you being followed-up by a dental specialist?	☐	☐	☐

HABITS Do you -	NO	NS	YES	**TREATMENTS** Please check off the following treatments you have had:	NO	NS	YES
Clench or grind your teeth while asleep?	☐	☐	☐	Orthodontic treatment (braces)?	☐	☐	☐
Bite your lips or cheeks regularly?	☐	☐	☐	Oral surgery?	☐	☐	☐
Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)?	☐	☐	☐	Periodontal treatment (gum surgery)?	☐	☐	☐
				Teeth ground or bite adjusted?	☐	☐	☐
Breath through your mouth while awake or asleep?	☐	☐	☐	Worn a bite plate or other appliance?	☐	☐	☐
				Dental implants?	☐	☐	☐

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general or local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive. I know that your office has a privacy code, and I can ask to see the code at any time. I agree that your office can collect, use and disclose personal information about me as set out in your office privacy policy.

Patient☐ **Parent**☐ **Guardian**☐ Date: ________ Signature: ____________

I wish to pay each visit as services are performed☐ Cash☐ Cheque☐ Interac☐ Credit Card☐ Other☐

I wish to discuss special arrangements for payments☐ *Interest of 2% per month on late payments will be charged automatically*