

**Patient Information and
Medical History Questionnaire**

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 with dosage and when medication taken.

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

Have you been vaccinated against COVID-19?

Yes No

If YES, when? _____

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	
CDAnet	<p>I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.</p> <p>_____</p> <p style="text-align: center;">Signature of patient or parent/guardian</p> <p>Date: _____ Patient I.D. # _____</p>

Dentist's Notes:

Dentist's Signature:

Date: _____

<u>MEDICAL ALERT</u>	<u>CONDITION</u>	<u>PREMEDICATION</u>	<u>ALLERGIES</u>	<u>ANAEST.</u>
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PATIENT NAME:	CHART NO:	DATE:
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REASON FOR INITIAL VISIT:

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

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

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

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment (braces)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bite your lips or cheeks regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment (gum surgery)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breath through your mouth while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teeth ground or bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Worn a bite plate or other appliance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Dental implants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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