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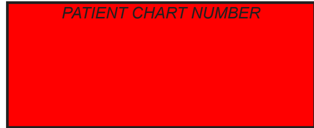

NEW PATIENT FORM

The following information is required by our office to thoroughly diagnose any condition and give you personal attention. This form is STRICTLY CONFIDENTIAL. *Please fill out the form completely.*

Personal Information

NAME		DATE OF BIRTH
ADDRESS		POSTAL CODE
HOME PHONE	CELL PHONE	EMAIL
OCCUPATION	EMPLOYER	WORK PHONE

HOW WOULD YOU LIKE TO BE CONTACTED? (*List in order, e.g. Cell, Work, Home, Email*)	PERSON RESPONSIBLE FOR YOUR ACCOUNT
IF CHILD, NAME OF MOTHER	IF CHILD, NAME OF FATHER

Dental Insurance

NAME OF INSURANCE PLAN	I.D. # or CERTIFICATE #	POLICY HOLDER'S EMPLOYER	DENTAL PLAN HOLDER'S NAME
POLICY OR PLAN NUMBER	DEPENDENT NUMBER	COVERAGE A B C Plan Max	PLAN HOLDER'S DATE OF BIRTH

Medical History

PERSONAL PHYSICIAN	SPECIALIST
CLINIC LOCATION	PHONE #

Do you have OR have you ever had (*Select all that apply*)

⑤ 1. hospitalization for illness or injury

2. an allergic reaction to:
   - ⑤ aspirin, ibuprofen, acetaminophen
   - ⑤ penicillin
   - ⑤ erythromycin
   - ⑤ tetracycline
   - ⑤ codeine
   - ⑤ local anesthetic
   - ⑤ fluoride
   - ⑤ metals (gold, stainless steel)
   - ⑤ latex
   - ⑤ any other medications

   ____

⑤ 3. to take antibiotics prior to a dental procedure

⑤ 4. heart problems / defect / pacemaker

⑤ 5. heart murmur / ventricular prolapse

⑤ 6. rheumatic fever / scarlet fever

⑤ 7. high blood pressure

⑤ 8. low blood pressure

⑤ 9. a stroke

⑤ 10. artificial prosthesis *(e.g. joints, stents, heart valve)* Date: _______________

⑤ 11. anemia or other blood disorder

⑤ 12. abnormal bleeding

⑤ 13. emphysema

⑤ 14. tuberculosis

⑤ 15. asthma

⑤ 16. breathing or sleep problems *(snoring, sinus, sleep apnea)*

⑤ 17. sinus problems

⑤ 18. kidney disease

⑤ 19. liver disease

⑤ 20. jaundice

⑤ 21. thyroid or parathyroid disease

⑤ 22. hormone deficiency

⑤ 23. high cholesterol

⑤ 24. diabetes (*circle*): Type 1 Type 2

⑤ 25. stomach or duodenal ulcer

⑤ 26. digestive disorders (gastric reflux)

⑤ 27. eating disorders (anorexia/bulimia)

Do you have OR have you ever had (*select all that apply*)

- ⑤ 28. osteoporosis/osteopenia (taking bisphosphonates)
- ⑤ 29. arthritis
- ⑤ 30. glaucoma
- ⑤ 31. contact lenses
- ⑤ 32. head or neck injuries
- ⑤ 33. epilepsy, convulsions (seizures)
- ⑤ 34. neurologic problems / alzheimers / memory loss
- ⑤ 35. viral infections and cold sores
- ⑤ 36. any lumps or swelling in the mouth
- ⑤ 37. dry mouth
- ⑤ 38. hives, rash, hay fever
- ⑤ 39. venereal disease
- ⑤ 40. hepatitis (type________)
- ⑤ 41. HIV / AIDS
- ⑤ 42. tumor, abnormal growth
- ⑤ 43. radiation therapy
- ⑤ 44. chemotherapy
- ⑤ 45. emotional problems
- ⑤ 46. psychiatric treatment
- ⑤ 47. antidepressant medication
- ⑤ 48. alcohol / drug dependency

Are you: (*Select all that apply*)

- ⑤ 49. presently being treated for any other illness
- ⑤ 50. aware of a change in your general health
- ⑤ 51. often exhausted or fatigued
- ⑤ 52. subject to frequent headaches
- ⑤ 53. a smoker, smoked previously, use tobacco
- ⑤ 54. Female – taking birth control pills
- ⑤ 55. Female – pregnant /nursing
- ⑤ 56. Male – prostate disorders

Additional Medical Information

____

____

List all medications, supplements, and/or vitamins taken within the last two years

Medication	Reason for taking

Describe any medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

____

Dental History

REFERRED BY	PREVIOUS DENTIST	HOW LONG HAVE YOU BEEN A PATIENT?
DATE OF LAST DENTAL EXAM / CLEANING	DATE OF LAST DENTAL XRAYS	DATE OF LAST TREATMENT *(eg. fillings, crowns, whitening)*

I ROUTINELY SEE MY DENTIST EVERY *(Select one only)*

⑤ 3 months ⑤ 4 months ⑤ 6 months ⑤ 12 months ⑤ not routinely

HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? *(Select one only)*

⑤ Excellent ⑤ Good ⑤ Fair ⑤ Poor

HOW OFTEN DO YOU:

BRUSH: ____________/day

FLOSS: ____________/week

BRUSH TONGUE: ____________/week

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? (*Briefly describe*)

____

____

Dental History Details (*Select all that apply*)

Treatment History

⑤ Are you fearful of dental treatment?

⑤ Have you had an unfavourable dental experience?

⑤ Have you ever had complications from past dental treatment?

⑤ Have you ever had trouble getting numb or reactions to local anesthetic?

⑤ Did you ever wear braces, have orthodontic treatment or had your bite adjusted?

⑤ Have you had any teeth removed?

Smile Characteristics

If you are not happy with the appearance and function of your teeth, what would you change?

⑤ Whiter teeth

⑤ Straighter teeth

⑤ Close spaces

⑤ Lengthen teeth

⑤ Contour / reshape teeth

⑤ Replace metal fillings

⑤ Repair chipped / broken teeth

⑤ Replace missing teeth

⑤ Repair worn teeth

⑤ Replace old crowns / caps that don't match

Gum, Bone, and Tooth Structure

⑤ Are any teeth sensitive to hot, cold, biting, or sweets?

⑤ Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?

⑤ Do you feel or notice any holes (ie. Pitting) in your teeth?

⑤ Have you ever been diagnosed or treated for periodontal (gum) disease?

⑤ Have you ever experienced gum recession?

⑤ Is there a history of periodontal disease in your family?

⑤ Do your gums bleed when brushing, flossing, or eating?

⑤ Are your teeth becoming loose?

⑤ Have you ever noticed an unpleasant taste or odor in your mouth?

⑤ Have you experienced a burning sensation in your mouth?

Bite and Jaw

⑤ Do you have any problems chewing gum or hard foods?

⑤ Have your teeth changed in the last 5 years, become shorter, thinner or worn?

⑤ Are your teeth crowding or developing spaces?

⑤ Do you have more than one bite or do you clench(squeeze) your teeth to make them fit together?

⑤ Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)

⑤ Do you have tension headaches or sore teeth?

⑤ Do you wear or have you ever worn a bite appliance? (night guard)

I hereby certify that the information given here is complete, true and correctly recorded, and I consent to examination and treatment agreed to be necessary or advisable.

Signature of Patient (or Parent / Guardian)

Date

Please submit this form to our staff at your earliest convenience