Welcome to DENTISTRY 390 commissioners west

Last Name	First Name	Initial	Date of Birth D/M/Y	Email

Address	City/Province	Postal Code	Work Phone Number

Home Phone Number	Cellular Number	Occupation	Employer	Do you have dental insurance?

Emergency Contact Name	Number	How did you hear about Dentistry 390?

Primary Dental Insurance

Name of Insured	Date of Birth D/M/Y	Employer

Insurance Carrier	Group Policy #	Division

SIN # or ID #	Certificate #	Coverage %	Deductible

Secondary Dental Insurance

Name of Insured	Date of Birth D/M/Y	Employer

Insurance Carrier	Group Policy #	Division

SIN # or ID #	Certificate #	Coverage %	Deductible

Health Questionnaire

To help ensure your well being while receiving treatment in our office, please answer the following questions. All information is confidential and for our records only.

1. Have you been examined and/or treated by a physician within the last year? ☐ Yes ☐ No
   Physician's Name and Number
2. Have you ever been seriously ill or hospitalized? ☐ Yes ☐ No
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? ☐ Yes ☐ No
4. Are you taking any medications or non-prescription drugs now? ☐ Yes ☐ No
   What?

Please indicate if you have had any of the following:

- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Congenital heart condition
- ☐ Heart attack
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Angina pectoris
- ☐ Blood pressure problems
- ☐ Heart trouble
- ☐ Lung/Breathing Problems
- ☐ Kidney/bladder problems
- ☐ Stomach/intestinal problems
- ☐ Hepatitis/jaundice
- ☐ Liver disease
- ☐ Diabetes
- ☐ Blood Disorders
- ☐ Pacemaker/artificial valves
- ☐ Infectious/communicable disease
- ☐ AIDS
- ☐ Positive testing for HIV virus
- ☐ Artificial Joints
- ☐ Tumors or growths
- ☐ Nervous/mental problems
- ☐ Epilepsy
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Inflammatory rheumatism
- ☐ Cortisone/steroid therapy
- ☐ Hives/skin rash
- ☐ Asthma
- ☐ Prolonged bleeding after injury
- ☐ Bruise easily
- ☐ Severe headaches
- ☐ Sinus trouble
- ☐ Sore throats
- ☐ Ear aches
- ☐ Trouble hearing
- ☐ Shortness of breath
- ☐ Chest pains
- ☐ Swollen ankles
- ☐ Heart palpitations
- ☐ Extra pillows for sleeping
- ☐ Persistent cough
- ☐ Blood in sputum
- ☐ Recent change in appetite
- ☐ Foods that you cannot eat
- ☐ Difficulty in swallowing
- ☐ Frequent indigestion/vomiting
- ☐ Feel thirsty much of the time
- ☐ Urinate more than 6x / day
- ☐ Painful, swollen joints
- ☐ Numb/prickling sensations
- ☐ History of broken bones
- ☐ Tendency to faint
- ☐ Fits, seizures or convulsions
- ☐ Tobacco
- ☐ History of family disease
- ☐ Alcoholic beverages
- ☐ Non-prescription drugs
- ☐ Other
- ☐ Pregnant (how many months)
- ☐ Past menopause

Do you have any allergies or had unusual reaction to any medications? ☐ Yes ☐ No ☐ Not Sure/Maybe. If yes, please indicate below:

☐ Aspirin ☐ Codeine ☐ Dental Anaesthetic ☐ Penicillin ☐ Latex ☐ Hayfever ☐ Foods ☐ Other

Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No

Is there anything else concerning your health Dentistry 390 should know?

Dental History

Date of Last Dental Visit Former Dentist

Purpose

Have you had regular dental care in the past? ☐ Yes ☐ No

Are you satisfied with the function and appearance of your teeth? ☐ Yes ☐ No

Do you have any oral habits such as clenching, grinding your teeth, or nail biting? ☐ Yes ☐ No

Do you have an unpleasant taste or odour in your mouth? ☐ Yes ☐ No

Are you presently in dental or facial PAIN? ☐ Yes ☐ No

When did the pain start?

Is any part of your mouth sensitive to temperature, pressure or sweets? ☐ Yes ☐ No If yes, what area? e.g. upper right?

Do your gums bleed when you brush your teeth ☐ Yes ☐ No

If yes, what area? e.g. upper right?

Have you had your wisdom teeth removed? ☐ Yes ☐ No

Have you ever had or do you now have any of the following:

- ☐ Bridges
- ☐ Gum Treatments
- ☐ Loose Teeth
- ☐ Orthodontics
- ☐ Lost fillings
- ☐ Sensitive Teeth
- ☐ Injury to face or jaw
- ☐ Extractions
- ☐ Partial Dentures
- ☐ Mouth Surgery
- ☐ Swelling in mouth
- ☐ Root Canals
- ☐ Bleeding Gums
- ☐ Sores or lumps in mouth

What dental condition concerns you now?

This is to certify that I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable including the use of local anaesthetic as indicated, and I will assume responsibility for the fees associated with those procedures and any costs incurred by this office in association with my account.

Your appointment will be reserved especially for you. If you are unable to keep your appointment we require 48 hours notice otherwise a fee may be charged for the missed appointment.

Patient/Parent/Guardian signature Date

Thank you. We hope that filling this form out prior to coming for your first visit was convenient for you. We look forward to meeting with you.