WELCOME TO OUR DENTAL OFFICE

ID #	(For office	use only)
I.D. #			
MEDICA	L ALERT	Y	N

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. PLEASE PRINT.

REGISTRATION I	NFORMATION - This inform	mation will enable us to	maintåin comm	unication with	you.
	Child Adult under guardian				
(last)	(first)	(initial)			
Name:			Dr. Mr.	Mrs. Ms.	Miss
Prefers to be called:		Language Preference			
Address: (street)	(apt.#)	(city)	(province)	(postal cod	de)
Home Phone: ()	Additional registrat	ion information if requir	ed by office:		
Bus. Phone: ()	Ext. Employ	er:		May we c	all you at work?
Cell Phone: () —		E-Mail a			
	Y Age: Sex:	Marital Status:	Name of Spouse	٠.	
	e: Whom may we				Ab
* *					
Are other family members	patients at our office? Yes \(\subseteq \text{Nat} \)	mes:			
MEDICAL PRIORIT	ry - This information will enab	le us to make any essent	ial contacts.		
Family Physician:				Phone: ()
Medical Specialist: (if presently under care)			Phone: ()	
In case of emergency, plea	ase contact:			Phone: ()
Nearest relative not living	with you:			Phone: ()
Passan for today's visit?	Examination Emergency	Other			
	you would like treated immediately				
is there a dental problem y	you would like treated illiniculately				
	RMATION - This information				
Person responsible for acco	ount: Self Spouse Other	Please complete all	information only	y if different tha	n above.
Name: (last)	(first)	(initial)		Phone: ()
Address: (street)	(apt.#)	(city)	(province)	(pos	tal code)
Employed by:				Phone: ()
	mation if required by office:				
	(For office use only) CASH CH	EQUE CREDIT C	ARD	OTHER	*
PRIMARY DENT	AL INSURANCE (Complete info	ermation only if required by office)	SECONDA	RY DENTA	AL INSURANCE
Subscriber's name:	D.O.B.	Subscriber's name:	Subscriber's name:		D.O.B.
Emp./Grp. policy holder:	Ins. yr. end	Emp./Grp. policy holder	Emp./Grp. policy holder:		Ins. yr. end
ns. Co.	Tel.	Ins. Co.			Tel.
Grp./Ind. policy No.	Cert. No.	Grp./Ind. policy No.		Cert. No.	
I.D.#	Max. Coverage.	I.D. #		Max. Coverage.	
% coverage: Basic Maj. Rest.	Ortho. Other Other	% coverage: Basic	Maj. Rest.	Ortho. Oth	er Other

HEALTH HISTORY

Date

DENTAL HISTORY/GENERAL RELEASE

HEALTH HISTORY UPDATES

CLINICAL EXAMINATION

PERIODONTAL SCREENING

DIAGNOSIS AND TREATMENT PLAN RECARE EXAMINATION

DIAGNOSIS AND TREATMENT PLAN

PROCRESS NOTES

PROCRESS NOTES

HEALIH HISTOR	Y	lease >	YES or NO to each question. If unsu	re of	a questio	on, please consult with the dentist.	YES	N
1. Are you being trea	ited f	or any	medical condition at present or Physician:	withir	the pa	ast two years? If yes, please explain:		
2. Have you been hospi	talize	d in the	e past two years?			Phone: cal examination? rescription drugs incl. herbal remedies		
4. Have you recently.	or a	re vou	Last co	omple	te physic	cal examination?		
1.			2.			3		
4.			5.			3		
5. Have you ever reacte	d adv	ersely	to any medications or injections? (Pl	ease c	ircle.) e	g. Penicillin or other antibiotics		
aspirin, codeine, loca	l anae	esthetic	(freezing), nitrous oxide, or any othe	r med	icine:	6		
6. Have you ever been a	dvise	d again	est taking any specific type of medicat	ion?				
other affergic condition	ons					tex Allergies, Skin Rashes, Hives, or any		
11 30, picase explain.						rtness of breath, or chest constriction?		
10. Do you bleed EXCES	SIVE	LY fro	es, Cancer or Heart Disease?					
1. Do your ankles, feet o	r han	ds swel	il?					
12. Has your weight, appe	al die	r energ	y level changed dramatically recently	?			H	
14. Do you experience she	ortnes	s of bre	eath or chest pain when taking a walk	or clir	nhing st	airs?		
5. Have you tested HIV	posit	ive? _						
7. Have you ever had any	ENT	SEVER	RE headaches, earaches, ear/throat inf	ection	is?		H	H
8. Do you wear eveglass	es or	contact	t lenses?					
0 0		000 1.1	2					
O. Do you smoke or use	any o	ther for	rms of tobacco?					H
21. Are you alcohol and/o	r drug	depen	ident?					
and. Have you re	ceive	d treatn	nent?					
2. INDICATE WHICH (OF T	HE FO	LLOWING YOU PRESENTLY HAV	VE OF	REVER	HAD:		
	YES	NO		YES	NO			
A.I.D.S.			Glaucoma			Lumus		
nemia			Head/neck injuries			Lupus Malignant Hymarthamaia		
angina pectoris			Heart disease or attack			Malignant Hyperthermia Mental/nervous disorder		
arthritis/rheumatism			Heart murmur			Mitral valve prolapse		
artificial heart valve			Heart pacemaker			Organ transplant/medical implant		
artificial joints(hip, knee)			Heart rhythm disorder			Psychiatric treatment		
Blood disorders			Heart surgery			Radiation treatment/chemotherapy		
ronchitis			Hepatitis A B C			Scarlet fever		
ancer			Herpes			Sickle cell disease		Ī
irculation problems ongenital heart lesions			High/Low blood pressure			Sinus trouble		
ortisone/steroid			Hodgkins disease			Stomach/intestinal problems/Ulcers		
rohn's disease			Hyper (Hypo) Glycemia			Stroke		
iabetes			Hypertension			Thyroid disease		
mphysema			Inflammatory bowel disease			Tuberculosis		
pilepsy or seizures			Jaundice			Venereal Disease		
ainting or dizzy spells			Kidney disease Liver disease			Other		
landular disorders			Liver disease Lung disease			Other		
2 Handle CHILD DATE	100			+		Other		
 Has the CHILD PATIEN had any of the following: 		ently	Measles				-	
(indicate approximate dat			Chicken Pox	H				
4. WOMEN ONLY:	Are y	ou pres	gnant or suspect you may be?	F	nected	delivery date?		
Are you breast feeding	?	1 - 2	Are you taking	gany	birth co	ntrol pills?		
Do you currently have	or ho	VA VICE	had in the most		1.1			
. Is there anything also of	or na	ve you	had in the past, any disease, conditionalth we should be made aware of?	or pr	oblem n	ot listed above?		
. Do you wish to sneak r	oout y	elv to t	alth we should be made aware of? he Doctor about any problem or med	0.51				
OTE. IT IC IMPORT	nival	cry to t	ne Doctor about any problem or med	ical co	onaition'	/		
OLE: IT IS IMPORTA	NTI	HAT	ANY CHANGE IN YOUR HEALT	H ST	ATUS	BE REPORTED TO OUR OFFICE.		
								-
	-							

Form: DMD Rev: 8

MEDICA		PREMEDICATION	ALLERGIES	ANAEST.	
ALERT	•.	2			
DENT	AL HISTORY	Please YES or NO to each question	. If unsure of a question, plea	se consult with the dentist.	
ls there a	dental problem you won	ald like treated immediately? Yes	□ No □	YE	ES NO
Date of y	our last dental visit?	Last dental cleaning	ng? Las	st x-rays?	
1. Have	you been seeing a dentist	regularly?	•		
2. Have	you ever had any of the fe				
	- Periodontal Treatmen	t? (treatment of the gums)			
		nt? (to straighten or realign teeth)			
	- A bite plate or any ot	her appliance?			
	- Your bite adjusted or	teeth ground?		or both of your jaw joints?)	
	- Oral surgery? (sur	gery in or about the mouth/jaw joint	, or implant surgery in one o		
		estion, who performed the surgery?			_ _
Are y	ou being followed up by a	dental specialist?			
Are th	here any growths or sore sp	oots in your mouth?		is?	
		ning or eating, or, do you suffer from	pain or swelling of your gum	s:?	
		th, or, have any of your teeth shifted?			
6. Does	food catch between your	eeth?			
7. Are a	ny of your teeth sensitive t	o heat, cold, sweets or pressure?			
8. Have	you been advised to take a	antibiotics before a dental appointment	nt?		
9. Do yo	ou use dental floss, proxab	rush or stimudents? How often? Do yo			
10. How	often do you brush your to	eeth? Do yo	ou feel that you have bad brea	th?	
11. Have		of the following jaw problems:			
	- Popping/clicking in y	your jaw joints?s, around your ear, or side of your fac			
		or closing?			
		elenched?			
		le chewing?			
12. Do yo	ou have any of the following				
		g your teeth while awake or asleep?			
	- Biting your cheeks or	r lips?			
	- Mouth breathing whi	le awake or asleep?			
		ets in your mouth (pencils, nails, pipe			
		cerns about having dental treatment?			
		arance of your teeth?			
2	and, What would you like t	to see changed?			
15. Have	you ever had an upsetting	g experience in a dental office, or any	complications during or foll	owing dental treatment, or,	
do you ha	ive any questions or conce	erns?			
		GENERAL 1	RELEASE		
I the unde	ersioned certify that I have	provided an accurate and complete per		tory and have not knowingly omit	ted ar
informati	ion. I have had the onno	provided an accurate and complete per ortunity to ask questions and receive	ve answers to any questions	regarding my medical - dental	histor
Should th	nere he any change in eith	er my health status or any other inf	ormation I have provided, I	will advise this dental office. I a	uthori
the dentist	t to perform diagnostic production	cedures as may be required to determine	ne necessary treatment. I unde	erstand that information provided	from
to my me	dical doctor or another he	alth care provider may be necessary.	I have been advised of the	privacy policy of the office and	that n
personal	information will be coll	ected, used and disclosed within	the guidelines of the policy	I understand that responsibi	ility fo
payment	of the dental services for	myself and my dependents is mine,	and I assume responsibility	for fees associated with these serv	vices.
X					-
, ((signature) Patient Pa	rent Guardian Guardian	(print na	me of guardian)	
Reviewed	l by Treating Dentist:		Date:		
пратт	TH HISTORY		DENTAL U	ISTORY/GENERAL REL	FAS
TEALI	TH HISTORY		DENIAL HI		
IEALT	H HISTORY UPDAT	TES		CLINICAL EXAMINA	ATIO

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