

Medical & Dental History Questionnaire

Title: Mr. Mrs. Ms. Mst. Miss. Dr.

Name: _____
(first) (last) (initial)

Nick Name: _____

Date of Birth (D/M/Y): _____

Home Address: _____

Suite: _____ City: _____ Prov. _____ Postal Code _____

Home Phone: _____

Cellular Phone: _____

Business Phone: _____

Email: _____

Please check preferred method of contact above

Occupation: _____

Name of guardian/parents: _____

(if under 18 or under guardianship)

Address (if not same as above): _____

Phone: (if not same as above): _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: _____

Relationship: _____

Phone: _____

(1) Name of family doctor: _____

Phone or address: _____

(2) Name of specialist: _____

Phone or address: _____

Pharmacy Name/Number: _____

Driver's License number: _____

OHIP number: _____

Do you have dental insurance? Yes No

Employer: _____

Primary Ins. Policy #/Cert.#: _____

Secondary Ins. Policy#/Cert.#: _____

How did you hear about our office? _____

MEDICAL HISTORY: 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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have been treated within the past year? If so, why?

Yes No Maybe/Not Sure _____

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain. Yes No Maybe/Not Sure

4. Are you taking any medications, non-prescription drugs, natural supplements of any kind? If yes please list with doses or provide list.

Yes No Maybe/Not Sure _____

5. Do you have any allergies? If yes please list below Yes No Maybe/Not Sure

a) medications: _____

b) latex / rubber products/ metals: _____

c) Other (eg. hayfever, foods, dyes): _____

6. Have you ever had a peculiar or adverse reaction to any medications or injections? Yes No Maybe/Not Sure

If yes, please explain: _____

7. Do you have or ever had asthma? Yes No Maybe/Not Sure

8. Do you have or ever had any heart or blood pressure problems? Yes No Maybe/Not Sure

9. Do you have or ever had a replacement or repair of a heart valve, infection of the heart (infective endocarditis), a heart condition from birth

(congenital heart disease) or a heart transplant? Yes No Maybe/Not Sure

10. Do you have a prosthetic or artificial joint? (i.e. knee or hip?) _____ Yes No Maybe/Not Sure
11. Do you have any condition or therapies that could affect your immune system? (i.e. chemotherapy, radiotherapy, leukemia, AIDS/HIV infection) _____ Yes No Maybe/Not Sure
12. Have you ever had hepatitis, jaundice (other than birth) or liver disease? _____ Yes No Maybe/Not Sure
13. Do you have a bleeding problem or bleeding disorder? _____ Yes No Maybe/Not Sure
14. Have you ever been hospitalized for any illness? Or had any surgeries? If Yes please explain _____ Yes No Maybe/Not Sure

15. Do you have or ever had any of the following? Please check.

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Chest pain, angina | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> lung disease | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> Drug/alcohol dependency |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> mitral valve | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> arthritis | <input type="checkbox"/> osteoporosis medications |
| <input type="checkbox"/> stroke | <input type="checkbox"/> prolapse | <input type="checkbox"/> cancer | <input type="checkbox"/> seizure(epilepsy) | (e.g.Fosamax, Actonel) |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> heart murmur | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> kidney disease | <input type="checkbox"/> pace maker |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> organ transplant | <input type="checkbox"/> malignant hypothermia | <input type="checkbox"/> mental health disorder |

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? _____

17. Are there any diseases that run in your family (e.g. diabetes, cancer, heart disease)

Yes No Maybe/Not Sure _____

18. Do you smoke /use tobacco/marijuana products? Yes No If yes, how much per day? _____ How many years? _____

FOR WOMEN ONLY:

1. Are you pregnant? Yes No Maybe/Not Sure Expected delivery date? _____

2. Are you breast feeding? Yes No

3. Are you on birth control pills? Yes No

DENTAL HISTORY

1. When was your last dental visit? _____ 2. When was your last cleaning? _____

3. Who was your previous dentist? _____ 4. Did you have xrays taken within the last 2 years? Yes No

5. How would you describe your dental health at present? _____ Good Fair Poor

6. What are your present dental concerns, if any?

Bleeding Gums Crooked teeth Cosmetic Loose Teeth Bad Breath Food trapping Sensitive Teeth

Toothache Loose Dentures Missing teeth/spaces want whiter teeth Other: _____

7. Are you dissatisfied with the appearance of your teeth? _____ Yes No Maybe/Not Sure

8. Any teeth extracted due to accident, decay or gum disease? _____ Yes No Maybe/Not Sure

If yes please explain _____

9. Have you ever had complications after extractions? _____ Yes No Maybe/Not Sure

10. Do you use any of the following as part of your oral hygiene regiment?

electric toothbrush floss softpics proxybrush stimudent flosswand toothpick rubbertip

waterpic fluoride rinse/tablet fluoridated toothpaste natural toothpaste prevident toothpaste

other(s): _____

11. Are you anxious during dental visits? _____ Yes No Maybe/Not Sure

12. Do you think you might like to have your dental treatment done with sedation? _____ Yes No Maybe/Not Sure

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made payment is due at each office visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist. I authorize the dentist to treat me and I assume full responsibility of the fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

X _____ date: _____
Signature, (parent or guardian if under 18 years old)