



# Patient Information

Name _____	Preferred Name _____	Date of birth _____	
Address _____	City _____	Prov _____ Postal Code _____	
Home phone _____	Cell phone _____	Work phone _____	
Preferred contact number? <u>H / C / W</u>	Email _____	How did you hear about us? _____	
Do you consent to email reminders? <b>YES / NO</b>	Text reminders? <b>YES / NO</b>	Newsletters? <b>YES / NO</b>	In-office promotions? <b>YES / NO</b>
Person to contact in case of emergency _____	Phone _____		
Do you have dental insurance? <b>YES / NO</b>	Do you have secondary dental insurance? <b>YES / NO</b>		

Person responsible for account/Responsible party: (If different from above):			
Name _____	Phone _____	Relationship to patient _____	
Address _____	City _____	Prov _____	Postal Code _____

## OFFICE POLICIES, PATIENT PRIVACY AND CONSENT FORM

### APPOINTMENTS

Please help us maintain the operation of our office so that we may assure uninterrupted treatment for you and other patients. Remember that once you have made an appointment, this time is *reserved for you*. Therefore, at least 2 BUSINESS DAYS NOTICE must be given if cancellation is absolutely necessary. If adequate notice is not given, a cancellation fee may be assessed to your account.

### PAYMENT OF FEES

1. This office is willing to accept direct payment from your dental plan for services which your plan covers.
2. If your dental plan does not cover the full cost of your treatment, you will be responsible for the difference between the amount paid by your plan and the amount charged by our office.
3. Your portion is due and payable on the day of your appointment unless other financial arrangements have been made.
4. You are responsible for providing the necessary information in order for us to directly bill your insurance company as well as informing us of any changes in this information.

### PATIENT PRIVACY AND CONSENT

Due to the new Government of Canada rules and regulations under the *Freedom of Information and Privacy Act*, we require all current and new patients to sign the following consent form. Maintaining the privacy of your personal information is integral to our office.

We are committed to collecting, using and disclosing your personal information in a responsible manner to ensure that our office complies with the provincial privacy legislation in force.

Our office collects personal information from patients required for the safe and efficient delivery of dental treatment, including information used for payment of dental service, and to communicate with other treating health care providers; including specialists and referring doctors. This information will be retained only as long as necessary to fulfill these purposes or as required by law. Our office takes reasonable steps to ensure the personal information under our control is protected from unauthorized use and disclosure. When it is no longer required, all personal information is destroyed prior to disposal.

To ensure accuracy of personal information, our office encourages patients and staff to maintain records that are accurate and up to date. Patients can notify our staff on their next visit, or contact the office if there is a change in any relevant information. For more information on our policies, or should you have any concerns regarding your personal information, please contact our office.

To further ensure that we have no difficulties in communicating with your insurance company or other doctors, we require that you sign this form to consent the release of your personal information.

### CONSENT

I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and consent to the use of local anesthetic agents. However, I reserve the right to refuse one or any of the above recommended forms of treatment.

I understand the above statements regarding payment of fees and accept the responsibility for payment for dental services provide for myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

Patient Signature (parent or guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_



# Medical History

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Name of Physician/and their specialty \_\_\_\_\_  
 Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_  
 What is your estimate of your general health?  Excellent  Good  Fair  Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO	YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e.taking bisphosphonates) _____	<input type="checkbox"/> <input type="checkbox"/>
2. an allergic reaction to			27. arthritis _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> aspirin			28. autoimmune disease	
<input type="checkbox"/> penicillin			(i.e. rheumatoid arthritis, lupus, scleroderma) _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> erythromycin			29. glaucoma _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> tetracycline			30. head or neck injuries _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> sulfa			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> local anesthetic			32. neurologic disorder (ADD/ADHD, prion disease) _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> fluoride			33. viral infections and cold sores _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			34. any lumps or swelling in the mouth _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> latex			35. hives, skin rash, hay fever _____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> other _____			36. STI/STD/HPV _____	<input type="checkbox"/> <input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months ___	<input type="checkbox"/>	<input type="checkbox"/>	37. hepatitis (type ___) _____	<input type="checkbox"/> <input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV/AIDS _____	<input type="checkbox"/> <input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/> <input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/> <input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/> <input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional difficulties _____	<input type="checkbox"/> <input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/> <input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/> <input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol use _____	<input type="checkbox"/> <input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR>3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	46. recreational drug use _____	<input type="checkbox"/> <input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>ARE YOU:</b>	
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/> <input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours	
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	(i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/> <input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/> <input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/> <input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/> <input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/> <input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/> <input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy/sensitive person _____	<input type="checkbox"/> <input type="checkbox"/>
23. diabetes (HbA1c= _____)	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/> <input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE – taking birth control pills _____	<input type="checkbox"/> <input type="checkbox"/>
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>	57. FEMALE – pregnant or breast-feeding _____	<input type="checkbox"/> <input type="checkbox"/>
			58. MALE – prostate disorders _____	<input type="checkbox"/> <input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

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

<u>Drug</u>	<u>Purpose</u>	<u>Drug</u>	<u>Purpose</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



# Dental History

Patient Name _____	Preferred Name _____	Date of Birth _____
How would you rate the condition of your mouth? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Previous Dentist(or office) _____	How long have you been a patient? _____ Month/Years	
Date of most recent dental exam _____	Date of most recent treatment (other than a cleaning) _____	
Date of most recent x-rays? _____ I routinely see my dentist every: <input type="checkbox"/> 3 mo. <input type="checkbox"/> 4 mo. <input type="checkbox"/> 6 mo. <input type="checkbox"/> 12 mo. <input type="checkbox"/> Not Routinely		
What is your immediate concern? _____		

## PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

### PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most) [\_\_\_\_\_] \_\_\_\_\_  YES  NO
2. Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
3. Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
4. Have you ever had trouble getting numb or had any reactions to local anaesthetic? \_\_\_\_\_  YES  NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_  YES  NO
6. Have you had any teeth removed? \_\_\_\_\_  YES  NO

### GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_  YES  NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_  YES  NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  YES  NO
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
11. Have you ever experienced gum recession? \_\_\_\_\_  YES  NO
12. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple? \_\_\_\_\_  YES  NO
13. Have you experienced a burning sensation in your mouth? \_\_\_\_\_  YES  NO

### TOOTH STRUCTURE

14. Have you had any cavities within the last 3 years? \_\_\_\_\_  YES  NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_  YES  NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_  YES  NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing in any part of your mouth? \_\_\_\_\_  YES  NO
18. Do you have any grooves or notches on your teeth near the gumline? \_\_\_\_\_  YES  NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  YES  NO
20. Do you frequently get food caught between any teeth? \_\_\_\_\_  YES  NO

### BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_  YES  NO
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? \_\_\_\_\_  YES  NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_  YES  NO
24. Have your teeth changed in the last 5 years, become shorter, thinner, or worn? \_\_\_\_\_  YES  NO
25. Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_  YES  NO
26. Are your teeth developing spaces or becoming loose? \_\_\_\_\_  YES  NO
27. Do you have more than one bite, or squeeze/shift your jaw to make your teeth fit together? \_\_\_\_\_  YES  NO
28. Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_  YES  NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_  YES  NO
30. Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_  YES  NO
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? \_\_\_\_\_  YES  NO
32. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

### SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth you would like to change? \_\_\_\_\_  YES  NO
34. Have you ever whitened (bleached) or teeth? \_\_\_\_\_  YES  NO
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_  YES  NO
36. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_