

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

**PATIENT NAME (SURNAME, GIVEN):** \_\_\_\_\_

**PREFERRED NAME:** \_\_\_\_\_

BIRTHDATE (DD/MM/YY): \_\_\_\_\_ SEX/GENDER: \_\_\_\_\_ HEIGHT/WEIGHT: \_\_\_\_\_

SCHOOL/OCCUPATION: \_\_\_\_\_

HOME ADDRESS (Nº, STREET, CITY, PROVINCE): \_\_\_\_\_

\_\_\_\_\_

POSTAL CODE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

CONTACT EMAIL: \_\_\_\_\_

May we leave a voicemail regarding your appointment at these numbers? Yes  No

Are you likely to be available on short notice for future appointments or changes? Yes  No

We would like to send you email and text communications which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us.

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_

RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

**FAMILY PHYSICIAN:** \_\_\_\_\_ PHONE: \_\_\_\_\_

**NAME OF MEDICAL SPECIALIST:** \_\_\_\_\_ AREA OF SPECIALTY: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_

**NAME OF MEDICAL SPECIALIST:** \_\_\_\_\_ AREA OF SPECIALTY: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_

**PARENT/GUARDIAN/CAREGIVER 1 INFORMATION**

NAME (SURNAME, GIVEN): \_\_\_\_\_

RELATION: \_\_\_\_\_

ADDRESS (Nº, STREET, CITY, PROVINCE): \_\_\_\_\_ PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**PARENT/GUARDIAN/CAREGIVER 2 INFORMATION (IF DIFFERENT THAN ABOVE)**

NAME (SURNAME, GIVEN): \_\_\_\_\_

RELATION: \_\_\_\_\_

ADDRESS (Nº, STREET, CITY, PROVINCE): \_\_\_\_\_ PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

**PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE**

(E.G. SCHEDULING APPOINTMENTS)

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

- |                                                     |                                                |                                                            |
|-----------------------------------------------------|------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Friend                     | <input type="checkbox"/> Family member         | <input type="checkbox"/> Colleague                         |
| <input type="checkbox"/> Staff member at our office | <input type="checkbox"/> Patient at our office | <input type="checkbox"/> Referral from health professional |
| <input type="checkbox"/> Website/Internet           | <input type="checkbox"/> Advertisement         | <input type="checkbox"/> Saw sign/Office in person         |
| <input type="checkbox"/> Other: _____               |                                                |                                                            |

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

\_\_\_\_\_  
Signature      PATIENT  PARENT  GUARDIAN  CAREGIVER       Date**INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING)**

SUBSCRIBER: \_\_\_\_\_  
RELATION: \_\_\_\_\_  
INSURANCE CO: \_\_\_\_\_  
POLICY PLAN #: \_\_\_\_\_  
DIVISION/SECT.#: \_\_\_\_\_  
SUBSCRIBER ID: \_\_\_\_\_

SUBSCRIBER: (SECONDARY) \_\_\_\_\_  
RELATION: \_\_\_\_\_  
INSURANCE CO: \_\_\_\_\_  
POLICY PLAN #: \_\_\_\_\_  
DIVISION/SECT.#: \_\_\_\_\_  
SUBSCRIBER ID: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

### PATIENT DENTAL HISTORY

1. Reason for today's visit: \_\_\_\_\_  
 \_\_\_\_\_

2. Do you have a dental problem that needs to be addressed as soon as possible? ..... Yes  No

3. Have you been visiting the dentist regularly? ..... Yes  No

4. Last dental visit \_\_\_\_\_ Cleaning \_\_\_\_\_ X-rays \_\_\_\_\_

5. How often do you brush your teeth? \_\_\_\_\_ Floss your teeth? \_\_\_\_\_

6. Do your gums bleed regularly? ..... Yes  No

7. Are your teeth sensitive to ..... Hot  Cold  Biting  Sweets  Sour  N/A

8. Do you feel any pain in your teeth? ..... Yes  No

9. Have you ever had any head, neck, or jaw injuries/surgery? ..... Yes  No

10. Do you have dry mouth or difficulty swallowing? ..... Yes  No

11. Do you snore or have sleep apnea? ..... Yes  No

12. Does your jaw crack, click or pop when opened widely? ..... Yes  No

13. Do you grind or clench your teeth during the day or night? ..... Yes  No

14. Do you bite your lips/cheeks frequently? ..... Yes  No

15. Have you ever experienced any growths, lumps or sore spots in your mouth? ..... Yes  No

16. Have you noticed any loosening/movement of your teeth? ..... Yes  No

17. Have you had periodontal (gum) treatment? ..... Yes  No

18. Have you had orthodontic (braces) treatment? ..... Yes  No

19. Have you ever had treatment by a dental specialist? ..... Yes  No

20. Have you had previous problems with dental treatment? ..... Yes  No

21. Are you satisfied with the appearance of your teeth? ..... Yes  No

22. Are you nervous/anxious/fearful during dental treatment? ..... Yes  No

23. Please list any other information that you feel we should have to provide you with the best possible dental care:

\_\_\_\_\_  
 \_\_\_\_\_

Signature PATIENT  PARENT  GUARDIAN  CAREGIVER

Date

Reviewed By Dentist

Date

**PATIENT NAME:** \_\_\_\_\_**MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)**

1. Do you have any health problems? ..... Yes  No   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
2. Has there been any change in your general health or weight in the past year? ..... Yes  No   
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
3. Are you currently being treated for any medical condition or have been treated in the last year? ..... Yes  No   
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. When was the last time you had a medical examination? \_\_\_\_\_  
Were any problems identified? ..... Yes  No   
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
5. Have you ever been hospitalized for any illnesses or operations? ..... Yes  No   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
6. Are you taking any medications, non-prescription drugs, homeopathic or herbal supplements, or hormones of any kind? ..... Yes  No   
If yes, please list and provide reason for taking: \_\_\_\_\_  
\_\_\_\_\_
7. Do you have any allergies or reactions? ..... Yes  No   
If yes, please list using the categories below:  
Medications \_\_\_\_\_  
Latex/rubber derived products \_\_\_\_\_  
Other (e.g. seasonal, foods, dyes) \_\_\_\_\_
8. Have you had an adverse reaction to any dental materials, injections or local anaesthetic? ..... Yes  No   
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
9. Do you have or have you ever had a replacement or a repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ..... Yes  No   
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
10. Have you been advised to take pre-medication (e.g. antibiotics) prior to dental treatment? ..... Yes  No   
If yes, please explain: \_\_\_\_\_
11. Do you have a prosthetic or artificial joint? ..... Yes  No   
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY CONTINUED ON NEXT PAGE**

PATIENT NAME: \_\_\_\_\_

**MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)**

12. Do you have any conditions or have undergone therapies that could affect your immune system? ..... Yes  No   
(Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

13. Have you ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders? ..... Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

14. Do you have a bleeding problem, bleeding disorder, bruising tendency, or have had a blood transfusion? ..... Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

15. Do you have any or have you ever had any of the following (check all that apply): ..... Yes  No

- |                                                |                                               |                                                                                 |
|------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> Fainting/Dizzy spells | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Hyper/Hypoglycemia                                     |
| <input type="checkbox"/> Eating disorder       | <input type="checkbox"/> Steroid therapy      | <input type="checkbox"/> Mental or Nervous disorder                             |
| <input type="checkbox"/> Stroke/TIA            | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Circulatory problems                                   |
| <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> Stomach ulcers       | <input type="checkbox"/> Blood transfusion                                      |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Other communicable disease/<br>Transmissible infection |
| <input type="checkbox"/> Heart murmur          | <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> Chest pain/Angina/Heart attack                         |
| <input type="checkbox"/> Asthma or Emphysema   | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Drug/Alcohol/Cannabis use or dependency                |
| <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Seizures/Epilepsy    | <input type="checkbox"/> Shortness of breath                                    |
| <input type="checkbox"/> Lung disease          | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Osteoporosis                                           |
| <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Thyroid disease      |                                                                                 |

16. Are there any conditions or diseases not listed above that you have or have had? ..... Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

17. Are there any diseases or medical problems that run in your family? ..... Yes  No

(e.g. diabetes, cancer, or heart disease)

18. Do you smoke, vape, use e-cigarettes or chew tobacco products? ..... Yes  No

19. Are you pregnant? ..... Yes  No

If yes, what is the expected delivery date: \_\_\_\_\_

20. Are you breastfeeding? ..... Yes  No

**MEDICAL HISTORY CONTINUED ON NEXT PAGE**

PATIENT NAME: \_\_\_\_\_

**MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)**

21. Do you identify as a person with a disability? ..... Yes  No   
If yes, please explain: \_\_\_\_\_
22. Have you recently travelled to areas where endemic diseases are present? ..... Yes  No
23. Have you recently experienced any new symptoms such as a cough, fever, chills, vomiting,  
diarrhea, rash or other illness since recent travel or otherwise? ..... Yes  No
24. Have you had a recent exposure to a communicable infectious disease? ..... Yes  No   
(e.g. measles, chicken pox or tuberculosis)
25. Have you recently received antimicrobial therapy? ..... Yes  No   
If so, for what reason? \_\_\_\_\_
26. Are your immunizations up to date? ..... Yes  No
27. Is there any additional information related to your health that has not been addressed above? ..... Yes  No   
If so, please advise: \_\_\_\_\_

\_\_\_\_\_  
Signature      PATIENT  PARENT  GUARDIAN  CAREGIVER \_\_\_\_\_  
Date\_\_\_\_\_  
Reviewed By Dentist\_\_\_\_\_  
Date