



WELCOME TO OUR OFFICE!

The information that is requested on this Questionnaire and Dental/Medical Health Form 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. **All information is confidential.** PLEASE PRINT.

Date: _____

Patient Information

Dr. Mrs. Mr. Ms.

Last Name: _____ First Name: _____ Initial: _____

Prefer to be called: _____ Date of Birth: _____ Age: _____

Sex: M F Marital Status: _____ Health Card #: _____

Home Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Home Tel.#: (____) _____ Cell #: (____) _____

Business Tel.#: (____) _____ Occupation: _____ E-mail: _____

Family Physician:

First Name: _____ Last Name: _____ Tel.#: (____) _____

Emergency Contact:

Name: _____ Relation: _____ Tel.#: (____) _____

Whom may we thank for referring you? _____

Insurance Information

Do you have dental insurance? YES NO

Primary Dental Insurance:

Name of Policy Holder: _____ Birthdate: _____

Company Name: _____

Group/Policy No: _____ Certificate/ID No: _____

Secondary Dental Insurance:

Name of Policy Holder: _____ Birthdate: _____

Company Name: _____

Group/Policy No: _____ Certificate/ID No: _____



Medical History Form

Patient Name: _____

Date: _____

PLEASE ANSWER ALL THE QUESTIONS

1. Are you currently under the care of a physician? YES NO Date of last physical exam: _____

2. Have you had any serious illnesses, operations, or hospitalizations in the last 5 years?

3. Do you have any allergies/adverse reactions to medications/other substances? (e.g. latex, metal, food/dyes, hay fever, local anesthetics)

4. Please check all appropriate answers to each medical condition below:

Check Each Item	YES	NO		YES	NO		YES	NO
Epilepsy/Seizures			High/Low Blood Pressure			Stomach Ulcers		
Fainting/Dizziness			Irregular Heartbeat			Jaundice/Liver Disease		
Migraine/Headaches			Congenital Heart Defect			Hepatitis A / B / C		
Mental Health Disorder			Mitral Valve Prolapse			Steroid Medication		
Depression			Artificial Heart Valve			Systemic Lupus Erythematosus		
Glaucoma/Cataracts			Scarlet/Rheumatic Fever			Kidney Disease or Dialysis		
Cold Sores (Herpes)			Heart Murmur			Artificial Joints		
Sinus Problems			Heart Surgery			Arthritis/Rheumatism		
Asthma			Heart Attack			Osteoporosis		
Emphysema/COPD			Stroke			Neck/Back Injury		
Tuberculosis/PPD+			Shortness of Breath			Cancer/Radiation Therapy		
Persistent Cough			Swollen Ankles			Venereal Disease		
Anemia			Cardiac Pacemaker			HIV/AIDS		
Sickle Cell Disease			Blood Thinners			Alcoholism		
Hemophilia			High Blood Cholesterol			Street Drugs/Addiction		
Bruise/Bleed Easily			Diabetes Type I/Type II			Unexplained Weight Change		
Blood Transfusion			Thyroid Disease			Excessive Urination		
Angina (Chest Pain)			Acid Reflux/Heartburn			Hard of Hearing		

5. Do you have or have you had any other disease, conditions, or illness not listed above? _____

6. Please list all medications with dose/frequency including over-the-counter, vitamins, and herbal remedies.

7. Do you need to take antibiotic premedication prior to dental appointments? YES NO

8. Do you use tobacco products? (e.g. smoking, snuff, chew) YES NO
If yes, how often? _____ How much? _____ Are you interested in stopping? _____

9. Have you had Bisphosphonate Therapy? (e.g. Aredia, Zometa, Fosamax, Actonel, Boniva, Didronel) YES NO

*10. Females Patients: Are you currently pregnant or nursing? YES NO Est. due date: _____
Please list any birth control pills or hormonal replacement therapy: _____

11. Are there any disease or medical problems that run in your family? (e.g. diabetes, heart disease or cancer) YES NO
If yes, please explain. _____



Dental History Form

Patient Name: _____

1. Reason for today's visit:

2. Date of last dental exam: _____

Date of last dental x-rays: _____

3. Have you been given oral hygiene instruction in: Brushing Flossing Other _____

4. How often do you brush? _____ How often do you floss? _____

5. Please check all conditions that apply to you below:

Check Each Item	YES	NO		YES	NO
Bad breath			Painful jaw/joints		
Dry mouth			Pain around ears		
Bleeding/sensitive gums			Injury to teeth/jaws		
Gum surgery			Difficulty chewing/chew on one side		
Food caught between teeth			Grind/clenching of teeth		
Sensitivity to sweets			Gag easily		
Sensitivity to heat or cold			Orthodontic treatment (e.g. braces)		
Sensitivity when biting			Oral surgery (e.g. extractions)		
Root canal treatment			Dental implants		
Loose teeth or broken fillings			Fear or concern about dental treatment		
Sores or growths in your mouth			Interested in improving smile		
Bite plate or appliance			Other: _____		

GENERAL RELEASE

I, the undersigned, acknowledge that I have provided an accurate and complete personal and medical - dental history. I have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I grant permission for my medical doctor or health care provider to be contacted for details and advice. I have been advised of the privacy policy of the office and I give my consent for my personal information to be collected, used, and disclosed within the guidelines of the policy; which includes the release and transfer of information and dental records to any third party (i.e. insurance payer, laboratories, health care providers) as is necessary and appropriate for my care. I understand that the health care provider reserves the right to determine which cases fall outside of his/her scope of practice, on which event the appropriate referral will be recommended. I acknowledge that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Print Patient or Parent / Legal Guardian Name

Treating Dentist Signature

Patient or Parent / Legal Guardian Signature

Date