WELCOME TO OU	R DENTAL OFFIC	E	(For office use only)
<u>s</u> 3		1.D. #	
Date		MEDIC	CAL ALERT Y N
The information that is requested on this Questionnain with the highest standard of dental care. The protection our office and we are committed to collecting, using	ction and privacy of your	personal infor	mation is important to
REGISTRATION INFORMATION - This is	nformation will enable us to r	naintain commu	nication with you.
The patient is an: Adult \square Child \square Adult under guar	rdianship Name of Guardi	an:	
Name: (first)	* *	Dr. 🗆 Mr. 🗆	Mrs. Ms. Miss
Prefers to be called:	Language Preference	:	
Address: (street) (apt.#)	(city)	(province)	(postal code)
Home Phone: () Additional regi	istration information if require	ed by office:	
Bus. Phone: () Ext. Em	ployer:E-Mail ac		
Date of Birth: MD_Y Age: Sex: Sex:			
Are other family members patients at our office? Yes	·		
MEDICAL PRIORITY - This information will e			
Family Physician:		Phone: ()
Medical Specialist: (if presently under care)		Phone: ()
In case of emergency, please contact:		Phone: ()
Nearest relative not living with you:		Phone: ()
Reason for today's visit? Examination Emergency Is there a dental problem you would like treated immedi			
FINANCIAL INFORMATION - This information	tion is necessary to process in	voices and appl	v payments.
Person responsible for account: Self Spouse O			
Name: (fir		Phone: (
Address: (street) (apt.#)	(city) (p	province)	(postal code)

CHEQUE

PRIMARY DENTAL INSURANCE (Complete information only if required by office) SECONDARY DENTAL INSURANCE

Subscriber's name:

Grp./Ind. policy No.

% coverage: Basic

Ins. Co.

I.D.#

Emp./Grp. policy holder:

D.O.B.

Tel.

Other

Ins. yr. end

Other

DENTAL HISTORY

Other

Cert. No.

Ortho.

Max. Coverage.

OTHER

D.O.B.

Tel.

Ins. yr. end

Phone: (

CREDIT CARD \square

Maj. Rest.

Maj. Rest.

Cert. No.

Ortho.

Max. Coverage.

Additional financial information if required by office: _

METHOD OF PAYMENT (For office use only) CASH

Employed by:

Subscriber's name:

Grp./Ind. policy No.

% coverage: Basic

Ins. Co.

I.D.#

Emp./Grp. policy holder:

Is t	nere a dental problem you would like treated immediately? Yes \(\square\) No \(\square\)	YES	S NO
Dat	e of your last dental visit? Last dental cleaning? Last x-rays?		
1	Have you been seeing a dentist regularly?		
	Have you ever had any of the following?		l
۷.	- Periodontal Treatment? (treatment of the gums)		
	- Periodontal Treatment? (treatment of the gums) - Orthodontic Treatment? (to straighten or realign teeth)		18
	- A hite plate or any other appliance?		-
	- A bite plate or any other appliance? - Your bite adjusted or teeth ground?		
	- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)		
	If you answered "yes" to the last question, who performed the surgery?When?		-
	Are you being followed up by a dental specialist?		
3.	Are you being followed up by a dental specialist? Are there any growths or sore spots in your mouth?		
4.	Are there any growths or sore spots in your mouth? Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?		
	Have you noticed any loose teeth, or, have any of your teeth shifted?	H	\parallel
6.	D = = f = 1 = 4 = 1		
7	Are any of your teeth sensitive to heat cold sweets or pressure?		
8.	Have you been advised to take antibiotics before a dental appointment?		
9.	Do you use dental floss, proxabrush or stimudents? How often?		
10.	How often do you brush your teeth? Do you feel that you have had breath?		
11.	How often do you brush your teeth? Do you feel that you have bad breath? Have you ever experienced any of the following jaw problems:		
	- Popping/clicking in your jaw joints?		
	- Popping/clicking in your jaw joints? - Pain in your jaw joints, around your ear, or side of your face?		
	- Difficulty in opening or closing?		
	- Pain when teeth are clenched?		lΗ
	- Pain or difficulty while chewing?	\parallel	
12.	Do you have any of the following habits?		
	- Clenching or grinding your teeth while awake or asleep?		
	- Biting your cheeks or lips?		
	- Mouth breathing while awake or asleep?		
	- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)?		lH
13.	Do you have any emotional concerns about having dental treatment?		lH
14.	Do you have any emotional concerns about having dental treatment? Have you ever had an upsetting experience in a dental office, or any complications during or following dental		$ \Box $
	treatment, or, do you have any questions or concerns?		
15	Are you unhappy with the appearance of your teeth?		lH
10.	and, What would you like to see changed?		$ \Box $
	unu, what would jou like to see changes.		
16.	Do you feel your dental health influences your overall health?		
	On a scale of 1 to 10, 10 being highest, how important is it for you to keep your natural teeth?		_
om med I w trea I ha with	GENERAL RELEASE (Please sign after completing medical questionnaire.) the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not keep the tited any information. I have had the opportunity to ask questions and receive answers to any questions regardical - dental history. Should there be any change in either my health status or any other information I have put advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine the transmitted. I understand that information provided from or to my medical doctor or another health care provider may be not been advised of the privacy policy of the office and that my personal information will be collected, used and the puddelines of the policy. I understand that responsibility for payment of the dental services for myself endents is mine, and I assume responsibility for fees associated with these services.	rding providences necessediscle	my led, sary ary
_	(signature) Patient Parent Guardian (print name of guardian)		_

FORM: RMSPRDHC REV:7

Reviewed by Treating Dentist:

Date:

Name:			D	.О.В.	Patient/Parent/Guardian Initial:	Date:
Please VES or NO to	each questio	on. If unsure of a question, plo	ease co	onsul	t with the dentist.	,
1. Are you being treated	d for any med	dical condition at present or wi	ithin th	ne pas	st two years? If yes, please expla	ain:
2. Have you been hospi	talized in the	past two years?	all		Phone: Phone: sical examination? scription drugs incl. herbal remed	
3. When was your last v	isit to a Physi	cian? Last co	omplet	e phy	sical examination?	1:
4. Have you recently, or	r are you pres	sently, taking any prescription	or nor	ı-pre:	scription drugs incl. nerbal remed	nes
l		2		_ 3		
4		5		6.	cle.) e.g.Penicillin, or otherantibio	
5. Have you ever reacted aspirin, codeine, local	d adversely to l anaesthetic (any medications or injections? freezing), nitrous oxide, or any	(Pleas other n	se ciro nedic	cle.) e.g.Penicillin, or otherantibio ine:	tics
6. Have you ever been a	dvised agains	t taking any specific type of med	dicatio	n?		
7. Do you have any of t	he following?	Asthma, Hay Fever, Food Alle	ergies,	Meta	l or Latex Allergies, Skin Rashes,	
Hives, or any other	allergic con	ditions?				
If so, please explain:	gic conditions	s result in headache, nausea, sw	elling,	shor	tness of breath, or chest constriction	on?
9. Is there a family histo	ry of Diabetes	s, Cancer or Heart Disease?			· ·	—
0. Do you bleed EXCES	SSIVELY from	n a cut or injury, or bruise easily	/?			
1. Do your ankles, feet	or nands swel etite or energ	l! v level changed dramatically red	ently?	l .		
3. Do you follow a spec	ial diet, or are	you on a diet pill therapy?	citing.			
4. Do you experience sh	ortness of bre	eath or chest pain when taking a	walk c	r clir	nbing stairs?	
5. Have you or anyone i	In your family	tested HIV positive or have He	epatitis	SAB	C?s?	—
/. Have you ever had an	iv iniury or su	rgery to your face or laws?	oat mie	ction	8:	
8. Do you wear eyeglas9. Do you have any hea	ses or contact	lenses?			10.00	
Are you wearing	the transdern	nal nicotine patch?				—
1. Are you alcohol and	or drug depen	ident?				_
and, Have you re	eceived treatm	ient? LLOWING YOU PRESENTLY				
22. INDICATE WHICH		LOWING YOU PRESENTLY			EVER HAD:	
	YES NO		YES	NO		
A.I.D.S.		Glaucoma			Lupus	
Anemia		Head/neck injuries			Malignant Hyperthermia	
Angina pectoris		Heart disease or attack			Mental/nervous disorder	
Arthritis/rheumatism Artificial heart valve		Heart murmur			Mitral valve prolapse	
Artificial joints(hip, knee)		Heart pacemaker Heart rhythm disorder			Organ transplant/medical implant Psychiatric treatment	
Blood disorders		Heart surgery			Radiation treatment/chemotherapy	
Bronchitis		Hepatitis A B C	18		Scarlet fever	ver
Cancer		Herpes	18		Sickle cell disease	,,,,
Circulation problems		High/Low blood pressure	15		Sinus trouble	
Congenital heart lesions		Hodgkins disease			Stomach/intestinal problems/Ulcers	;
Cortisone/steroid		Hyper (Hypo) Glycemia			Stroke	
Crohn's disease Diabetes		Hypertension			Thyroid disease	
Emphysema		Inflammatory bowel disease			Tuberculosis	
Epilepsy or seizures		Jaundice			Venereal Disease	
ainting or dizzy spells		Kidney disease Liver disease	IH.		Other	—
Glandular disorders		Liver disease Lung disease			Other	
2 II 4 CHUD BATTE	NE :				Other	
 Has the CHILD PATIES had any of the followin 		Measles			Strep throat	
(indicate approximate d	-	Chicken Pox	IH.		Tonsillitis	
(muicate approximate d	шіс.) ——————					
24. Do you currently have	e, or have you	had in the past, any disease, co	nditio	n or p	roblem not listed above?	
Do you wish to speak	privately to	the Doctor about any problem of	or medi	ical c	ondition?	
7. Women only: Are you	pregnant or su	spect you may be? Expected	l delive	rv dat	e? Are you breast feeding?	
Are you taking any birt	h control pills?	Women over 50: Are vo	ou awar	e of v	our bone mineral density?	