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.

☐Chest pain, angina	☐rheumatic fever	☐lung disease	☐stomach ulcers	☐Drug/alcohol dependency
☐Heart attack	☐mitral valve prolapse	☐tuberculosis	☐arthritis	☐osteoporosis medications (e.g.Fosamax, Actonel)
☐stroke		☐cancer	☐seizure(epilepsy)	
☐shortness of breath	☐heart murmur	☐steroid therapy	☐kidney disease	☐pace maker
☐diabetes	☐thyroid disease	☐organ transplant	☐malignant hypothermia	☐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/NotSure_____

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)