



Name First : _____ Last _____ DOB: ____ / ____ / ____

Address: _____ City : _____

Province : _____ Postal Code : _____

Primary Phone Number : (____)- ____ - _____ Secondary Phone Number : (____)- ____ - _____

Emergency Contact : _____ Emergency Number : (____)- ____ - _____

Referred By : _____

Not referred? How did you find us? _____

Insurance Plan 1:

Subscriber Name : _____ Birth Date : ____ / ____ / ____

Company Name : _____

Insurance Company : _____ Group Policy Number : _____

Subscriber ID : _____

Insurance Plan (Secondary):

Subscriber Name : _____ Birth Date : ____ / ____ / ____

Company Name : _____

Insurance Company : _____ Group Policy Number : _____

Subscriber ID : _____

Medical Profile

- 1) Medical Physician:

- 2) Medical Physician Telephone (if known): (____)-____-_____
- 3) Date of Last Visit to Physician:

- 4) Medical Specialist:

- 5) Medical Specialist Telephone (if known): (____)-____-_____
- 6) Date of last visit to Medical Specialist:

- 7) Do you believe you are in good health? If no, explain N Y
- 8) Describe any notable changes in the past 2 years.

- 9) Describe any reasons why you have been hospitalized in the last 2 years.

- 10) Have antibiotics ever been suggested prior to dentistry? N Y
- 11) List any medications you are currently taking either on your own (over the counter) or prescribed by your doctor.

- 12) Have you taken any cortisteroids in the last six months? N Y
- 13) Have you ever had any allergic or adverse reaction to any medication or drug including anesthetic? N Y
- 14) Are you allergic to latex, plastic bandages or metal? N Y
- 15) List any other allergies:

- 16) Describe any special dietary needs:

- 17) If female, are you currently taking birth control pills? N Y
- 18) Is there a chance that you may be pregnant? N Y
- 19) If YES, please specify your due date: ____/____/_____
- 20) Please describe anything else we can do to make your appointments more comfortable.

In each of the following, please check off any symptom that describes your current medical profile and history. (√) check mark indicates "YES"

- | | | | |
|--|--------------------------|-------------------------------------|--------------------------------------|
| Severe Headaches | <input type="checkbox"/> | Migraine Headaches | <input type="checkbox"/> |
| Fainting | <input type="checkbox"/> | Dizzy Spells | <input type="checkbox"/> |
| Epilepsy or seizures | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> |
| Psychiatric Disorder | <input type="checkbox"/> | Eating Disorder | <input type="checkbox"/> |
| Sensory / Communication Disorder | <input type="checkbox"/> | | |
| ----- | | | |
| Learning or behavioral disorder | <input type="checkbox"/> | | |
| Skin rashes | <input type="checkbox"/> | Skin Cancer | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Artificial Joints | <input type="checkbox"/> |
| Sore Muscles | <input type="checkbox"/> | Night Sweats | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | | |
| ----- | | | |
| Heart Disease | <input type="checkbox"/> | Heart Attack : when? ____/____/____ | |
| Heart Failure | <input type="checkbox"/> | Swollen Ankles | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> |
| Artificial Valve | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Aneurysm | <input type="checkbox"/> | | |
| Congenital heart defect | <input type="checkbox"/> | | |
| Mitral Valve Prolapse | <input type="checkbox"/> | | |
| Heart surgery or transplant | <input type="checkbox"/> | | |
| High/Low blood pressure (last reading) _____ | <input type="checkbox"/> | | |
| ----- | | | |
| Easy bruising | <input type="checkbox"/> | Bleeding tendency | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Sickle Cell disease | <input type="checkbox"/> |
| Hemophilia | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> |
| Blood Transfusion or products | <input type="checkbox"/> | | |
| Seasonal Allergies | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> |
| Sinus Problems | <input type="checkbox"/> | Asthma | <input type="checkbox"/> |
| Chronic cough | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Cystic fibrosis | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | | |
| Diabetes | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> |
| Hodgkin's disease | <input type="checkbox"/> | Glandular disorder | <input type="checkbox"/> |
| Jaundice | <input type="checkbox"/> | Bladder Problems | <input type="checkbox"/> |
| Kidney Problems | <input type="checkbox"/> | Kidney transplant | <input type="checkbox"/> |
| HIV infection | <input type="checkbox"/> | Urinary infection | <input type="checkbox"/> |
| Sexually Transmitted disease | <input type="checkbox"/> | | |
| AIDS or AIDS-related diseases | <input type="checkbox"/> | | |
| Ulcers | <input type="checkbox"/> | Bowel disease | <input type="checkbox"/> |
| Persistent diarrhea | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> Type: _____ |
| Liver disease | <input type="checkbox"/> | Cirrhosis | <input type="checkbox"/> |
| Use tobacco | <input type="checkbox"/> | Use alcohol | <input type="checkbox"/> |
| Organ transplant | <input type="checkbox"/> | Tumor or cancer | <input type="checkbox"/> |
| Radiation therapy | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> |

Dental Profile

- 1) Are you answering these questions for a child or ward? N Y
- 2) If so, does your child clean his/her own teeth? N Y
- 3) What has prompted your visit to our office today?

- 4) When was your last dental hygiene visit?

- 5) How frequently do you normally visit a dental office?

- 6) How recently have you had dental x-rays taken?

- 7) Name of previous dentist:

- 8) Do you frequently eat or drink foods with high sugar content? N Y
- 9) Have you had neck or shoulder aches? N Y
- 10) Have you ever had difficulty opening or closing your mouth? N Y
- 11) Have you ever had clicking or popping sounds in your jaw? N Y
- 12) Do you wake up with soreness in your face or neck muscles? N Y
- 13) Do you feel like you grind or clench your teeth? N Y
- 14) Do you favor one side of your mouth when you eat? N Y
- 15) Does your jaw get sore during or after dental treatment? N Y
- 16) Have you ever experienced any injuries to your face or jaw? N Y
- 17) Do you wear a splint when you sleep or during the day? N Y
- 18) Do you regularly get food caught between your teeth? N Y
- 19) Do you suffer frequently from canker or cold sores? N Y
- 20) Do you suffer from dryness of the mouth? N Y
- 21) Do any of the following habits apply to you: *(please specify below)*
 Lip or Nail biting chewing or holding objects in your mouth
 Mouth Breathing Other? _____
- 22) Do you ever have burning sensations in your lips or tongue? N Y
- 23) Have your gums ever been swollen or tender? N Y
- 24) Do you feel that you have bad breath at times? N Y
- 25) Do your gums bleed when brushing, chewing or flossing? N Y
- 26) Are your teeth ever sensitive to cold or sweetness? N Y
- 27) Are your teeth sensitive to heat or pressure? N Y
- 28) When bending down, do your teeth hurt? N Y
- 29) Have you noticed any movement in your teeth? N Y
- 30) Have you had a bump or swelling on your gums? N Y
- 31) A dentist has adjusted the way your teeth come together N Y
- 32) Have you ever had treatment for gum disease? N Y
- 33) If yes, would you like to learn about alternative treatments to help prevent further disease progression? N Y
- 34) On a scale of 1-10, rate the appearance of your smile : _____
- 35) On a scale of 1-10, rate where you would like your smile: _____
- 36) Is there anything you would like to change about your smile? N Y
- 37) Would you like a whiter smile? N Y
- 38) Have you ever had braces? N Y
- 39) If so, do you wear retainers? N Y
- 40) Interested in straightening your teeth or correcting your bite? N Y
- 41) Do you feel nervous about being at the dentist? N Y
- 42) If so, on a scale of 1-10, how nervous do you feel? _____
- 43) Do you have a bad gag reflex? N Y
- 44) Would you like to know more about options to relax you during dental or hygiene treatment? N Y
- 45) Do you have missing teeth? N Y
- 46) If so, would you like to know options to replace them? N Y
- 47) Do you wear a partial or full denture? N Y
- 48) Is it full or partial? _____
- 49) Are you happy with how your denture fits? N Y
- 50) How old are your current dentures? _____
- 51) Would you like your denture adjusted or relined? N Y
- 52) Do you still have your wisdom teeth? N Y
- 53) Do you play sports that could cause injury to your teeth? N Y
- 54) Do you participate in high performance sports? N Y
- 55) Do you often feel tired during the day? N Y
- 56) Do you have a general lack of energy? N Y
- 57) Do you snore? N Y
- 58) Have you ever been diagnosed with sleep apnea? N Y
- 59) Do you have any particular concerns or preferences that we should be aware of regarding your dental care and treatment?

- 60) Are there any aspects of dentistry that you would like to hear more about?

