WELCOME TO OUR DENTAL OFFICE

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form. PLEASE PRINT.

1. PERSONAL INFORMATION

◯ Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss.

Name:______________________________ **Date of Birth**____________ **Age:**___
First Last DD/MM/YYYY

Address:____
Street Apt. # City Postal Code

Telephone: Home #______________ Cell #______________ Work #______________

May we text you to confirm appointments? ◯ Yes ◯ No

Occupation:____________________ **Place of Business:**____________________

May we call you at work? ◯ Yes ◯ No

Email Address:______________________________

May we email you to confirm appointments? ◯ Yes ◯ No

In case of Emergency,
Please Notify:____
Name Relationship Phone #

Family Physician:______________________________ **Phone #**______________
Name

Family Dentist:______________________________ **Phone #**______________
Name

2. MEDICAL HISTORY

1. **Are you currently in good health?** ◯ Yes ◯ No

   If NO please explain____

2. **Have you been under the care of a physician during the last two years?** ◯ Yes ◯ No

   If YES please explain____

3. **Do you have a sensitivity or allergy to:**
   - ◯ Penicillin
   - ◯ Erythromycin
   - ◯ Tetracycline
   - ◯ Aspirin/Anti-inflammatory pills
   - ◯ Latex
   - ◯ Local Anaesthetic (dental freezing)

4. **Do you have any other sensitivities/allergies not listed above?**______________________________

5. **Do you smoke or use any other forms of tobacco?** ◯ Yes
   How many/much per day:____________________

6. **Are you alcohol and/or drug dependant?** ◯ Yes
   If YES have you received any treatment? ◯ Yes

7. Please list any pills currently taken: (Prescription & non-prescription drugs, vitamins, herbal meds, Aspirin, etc.)

NAME	REASON	NAME	REASON

8. Please check if you have or had any of the following:

◯ Anemia
◯ Artificial Heart Valve
◯ Artificial Joints (hip, knee, etc)
◯ Asthma
◯ Blood Disorder
◯ Bronchitis
◯ Cancer (type)
◯ Circulatory Problems
◯ Cholesterol (High)
◯ Diabetes
◯ Emphysema
◯ Epilepsy
◯ Heart Disease
◯ Heart Attack
◯ Heart Murmur
◯ Heart Pacemaker
◯ Heart Arrhythmia
◯ Heart Surgery
◯ Hepatitis (A, B, C, D)
◯ Herpes
◯ High Blood Pressure
◯ Low Blood Pressure
◯ HIV/AIDS
◯ Hypoglycemia
◯ Kidney Disease
◯ Liver Disease
◯ Lung Disease
◯ Malignant Hyperthermia
◯ Mitral Valve Prolapse
◯ Organ Transplant
◯ Osteoporosis
◯ Radiation Therapy
◯ Chemotherapy
◯ Sinus Problems
◯ Stomach/Intestinal Problems
◯ Stroke
◯ Thyroid Problems
◯ Tuberculosis

9. List any other illness not included above____

3. DENTAL HISTORY

1. When was your last dental visit?____

2. Date of last dental cleaning? ______________________________________

3. Are you currently in pain? ◯ Yes

4. Do your gums bleed when: ◯ Brushing ◯ Flossing ◯ Spontaneously

5. Do your gums feel swollen or tender? ◯ Yes

6. Are you aware of any loose teeth? ◯ Yes

7. Are your teeth sensitive to: ◯ Cold ◯ Hot ◯ Sweets

8. How often do you brush your teeth? ______________________

9. Have you had any of the following dental treatments in the past?
   - Orthodontic treatment (braces) ◯ Yes
   - Oral Surgery (extractions, jaw surgery) ◯ Yes
   - Periodontal treatment (gum treatment) ◯ Yes

10. Are you anxious about receiving dental treatment? ◯ Yes

11. Do you require Antibiotic coverage prior to dental cleanings? ◯ Yes
    If YES which antibiotic do you take?________________________