Perth-Andover
DENTAL

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form.
PLEASE PRINT

PATIENT NAME: ____________________

PREFERRED NAME: ____________________

BIRTHDATE(DD/MM/YY): ____________________ GENDER: ____________________

HEIGHT/ WEIGHT: ____________________ SCHOOL / OCCUPATION: ____________________

HOME ADDRESS (N°, STREET): ____________________

CITY: ____________________ PROVINCE: __________ POSTAL CODE: ____________

HOME PHONE: ______________ CELL PHONE: ______________ OTHER: ________

EMAIL: ____________________

May we leave a voicemail regarding your appointment at these numbers? YES ☐ NO ☐

We would like to send you email and text communications which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us. ☐

IN CASE OF EMERGENECY NOTIFY: ____________________

RELATION: ____________________ PHONE: ____________________

FAMILY DOCTOR: ____________________ PHONE OR ADDRESS: ____________________

MEDICAL SPECIALIST: ____________________ AREA OF SPECIALTY: ______________

PHONE OR ADDRESS: ____________________

PARENT / GUARDIAN / CAREGIVER INFORMATION (if applicable)

NAME: ____________________

PHONE: ____________________ OTHER PHONE: ____________________

Can this person have access to this file? Yes ☐ No ☐

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

EDI Signature: I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes the same.

____________________ ____________________

Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

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PATIENT DENTAL HISTORY:

1. Reason for today's visit: ____________________
2. Last dental visit: ____________ Cleaning: ____________ X-rays: ____________
3. How often do you brush your teeth? ____________ Floss your teeth? ____________
4. Do your gums bleed regularly? .... YES ☐ NO ☐
5. Are your teeth sensitive to.......... Hot ☐ Cold ☐ Sweets ☐ Sour ☐ Biting ☐ N/A ☐
6. Have you ever had any head, neck, or jaw injuries/surgery? .... YES ☐ NO ☐
7. Do you have dry mouth or difficulty swallowing? .... YES ☐ NO ☐
8. Do you snore or have sleep apnea? .... YES ☐ NO ☐
9. Does your jaw crack, click or pop when opened widely? .... YES ☐ NO ☐
10. Do you grind or clench your teeth during the day or night? .... YES ☐ NO ☐
11. Do you bite your lips/ cheeks frequently? .... YES ☐ NO ☐
12. Have you ever experienced any growths, lumps or sore spots in your mouth? .... YES ☐ NO ☐
13. Have you had.......... periodontal (gum) treatment ☐ orthodontic (braces) treatment ☐ N/A ☐
14. Have you had previous problems with dental treatment? .... YES ☐ NO ☐
15. Are you satisfied with the appearance of your teeth? .... YES ☐ NO ☐
16. Are you nervous/anxious/fearful during dental treatment? .... YES ☐ NO ☐
17. Please list any other information that you feel we should have to provide you with the best possible dental care: ____________________

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PATIENT MEDICAL HISTORY (please select yes or no to each question)

1. Do you have any allergies or reactions? .... YES ☐ NO ☐
   If yes, please list using the categories below:
   Medications ____________________
   Latex / Rubber derived products ____________________
   Other (e.g. seasonal, foods, dyes) ____________________
2. Have you had an adverse reaction to any dental materials or local anaesthetic (freezing)? .... YES ☐ NO ☐
   If yes, please explain: ____________________
3. Have you been advised to take any pre-medication (e.g. antibiotics) prior to dental treatment? .... YES ☐ NO ☐
   If yes, please explain: ____________________
4. Do you have a prosthetic or artificial joint? .... YES ☐ NO ☐
   If yes, please explain: ____________________
5. Have you ever been hospitalized for any illnesses or operations? .... YES ☐ NO ☐
   If yes, please explain: ____________________

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6. Please list any of the following and provide reason for taking:
   Medications: ______________________________
   Non-prescription drugs: ______________________________
   Homeopathic / Herbal Supplements: ______________________________
   Hormones: ______________________________
7. Do you have a bleeding disorder, bruising tendency, or have had a blood transfusion? .... YES ☐ NO ☐
   If yes, please explain: ______________________________
8. Do you smoke, vape, chew tobacco products or use e-cigarettes? .... YES ☐ NO ☐
9. Has there been any change in your general health or weight in the past year? .... YES ☐ NO ☐
   If yes, please explain: ______________________________
10. Are you pregnant? .... YES ☐ NO ☐
11. Are you breastfeeding? .... YES ☐ NO ☐
12. Do you identify as a person with a disability? .... YES ☐ NO ☐
    If yes, please explain: ______________________________
13. Do you have any or have you had any of the following (CHECK ALL THAT APPLY):

☐ Fainting
☐ Eating Disorder
☐ Stroke / TIA
☐ Rheumatic Fever
☐ Mitral valve prolapse
☐ Heart Murmur
☐ Asthma or Emphysema
☐ Pacemaker
☐ Lung Disease
☐ Tuberculosis
☐ Cancer
☐ Chemotherapy
☐ HIV infection / AIDS
☐ Radiotherapy
☐ Leukemia
☐ Steroid Therapy
☐ Diabetes
☐ Stomach ulcers
☐ High blood pressure
☐ Low blood pressure
☐ Arthritis / Rheumatism
☐ Seizures / Epilepsy
☐ Circulatory problems
☐ Chest pain /Angina / Heart attack
☐ Heart condition at birth (congenital heart disease)
☐ Heart transplant
☐ Replacement/repair heart valve
☐ Infection of heart (infective endocarditis)
☐ Kidney disease
☐ Thyroid disease
☐ Hypo/Hyperglycemia
☐ Mental / Nervous disorder
☐ Drug / Alcohol/ Cannabis use or dependency
☐ Shortness of breath
☐ Osteoporosis
☐ Liver disease
☐ Jaundice
☐ Hepatitis
☐ Gastrointestinal disorders

14. Is there any other additional information related to your health that has not been addressed above?

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Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ ______________ Date

____
Reviewed by Dentist ______________ Date