Personal Information

First & Last Name: _____ Preferred Name: _____

Birth Date: _____ *(DD)* _____ *(MM)* _____*(YYYY)* Age: _____ ☐ Adult ☐ Child

Address: _____

City: _____ Province: _____ Postal Code: _____

Home: (_____) -_____-_____ Cell: (_____) -_____-_____ Email address: _____

May we contact you via? ☐ Phone call ☐ Text message ☐ Email

In case of emergency who should we call? _____ Phone number: _____

Please mark any that apply with "✘" or "✓"

☐Anemia	☐Emphysema	☐Head / Neck Injury	☐Rheumatic Fever
☐Angina	☐Epilepsy / Seizures	☐Herpes	☐STD's, HIV, AIDS
☐Asthma / Hay Fever	☐Fainting / Dizziness	☐Jaundice	☐Sickle Cell
☐Arthritis	☐Glandular Disorder	☐Kidney Disease	☐Stroke
☐Bronchitis	☐Glaucoma	☐Liver Disease	☐Sinus Problems
☐Blood Disorders	☐Heart Attack	☐Lung Disease	☐Strep Throat
☐Bowel Disease	☐Headaches / Migraines	☐Low Blood Pressure	☐Scarlet Fever
☐Cancer	☐Hearing Impairment	☐Lupus	☐Snoring / Sleep Apnea
☐Chrone's Disease	☐Heart Murmur	☐Lyme Disease	☐Tumor / Growth
☐Cortisone / Steroids	☐Heart Pacemaker	☐Mental Disorders	☐Thyroid Disease
☐Chronic Dry Mouth	☐Heart Palpitations	☐Mitral Valve Prolapse	☐Tuberculosis
☐Circulatory Problems	☐Valve Replacement	☐Medical Implant	☐Tonsillitis
☐Diabetes	☐Hepatitis - _____	☐Organ Transplant	☐Ulcers
☐Depression	☐High Blood Pressure	☐Osteoporosis	
☐Digestive Problems	☐Hodgkin's Disease	☐Psychiatric Treatment	
☐Endocrine Disorders	☐Hypertension	☐Radiation Therapy	☐NONE

Female Patients

Is there a chance you could be pregnant? ☐Yes ☐No If yes, when is your due date? _____

Are you currently nursing? ☐Yes ☐No Are you currently on any form of birth control? ☐Yes ☐No

Are you currently taking hormones? ☐Yes ☐No

Adolescent Patients

Are all vaccinations up to date? ☐Yes ☐No

Has the child had any of the following? ☐Measles ☐Mumps ☐Chickenpox

Medical information and History

Have you ever been advised to take antibiotics before dental appointments? ☐Yes ☐No Are you currently being treated for any medical condition at present or within the past 2 years? ☐Yes ☐No

Do you have frequent severe headaches, earaches, ear / throat infections? ☐Yes ☐No

Have you ever had an operation or surgery of any kind? ☐Yes ☐No

If so, what was it and when? _____

Have you ever reacted adversely to or have been told not to take any medications or injection ☐Yes ☐No
If so, what was it and when? _____

Are you taking any prescription or non-prescription medication including herbal remedies or vitamins? ☐Yes ☐No
If so, Please list all: _____

Do you use recreational drugs?	☐Yes ☐No			
Do you drink alcohol?	☐Yes ☐No	☐Daily	☐Weekly	☐Occasionally
Do you smoke tobacco or marijuana?	☐Yes ☐No	☐Daily	☐Weekly	☐Occasionally

Please list allergies:_____

Dental History

Date of your - Last dental visit: _____ **Last dental hygiene:** _____ **Last x-rays:** _____

Is there a dental problem you would like treated immediately? ☐Yes ☐No If so, please explain? _____

I brush	☐Never ☐Occasionally	☐Weekly	☐Daily ☐More than once daily	
I floss	☐Never ☐Occasionally	☐Weekly	☐Daily ☐More than once daily	

General:

Have you been seeing a dentist regularly?	☐Yes ☐No	Are any of your teeth sensitive to hot or cold?	☐Yes ☐No
Do you feel that you have bad breath?	☐Yes ☐No	Do your gums bleed when brushing or flossing?	☐Yes ☐No
Do you wear a night guard?	☐Yes ☐No	Have you ever had braces or Invisalign?	☐Yes ☐No
Does food catch between your teeth?	☐Yes ☐No		

In association with your jaw; Do you:

Do you experience tired jaw or pain when chewing or have difficulty opening or closing? ☐Yes ☐No
Do you hear popping or clicking when you open or do you experience pain in your jaw, ears or face? ☐Yes ☐No

Have you ever been treated for TMJ (jaw joint) problems? ☐Yes ☐No
Do you have any trauma to your head, neck or jaw (even in early childhood)? ☐Yes ☐No

Oral habits:

Do you clench or grind your teeth when awake or asleep or mouth breath while awake or asleep? ☐Yes ☐No
Do you chew gum or bite your cheeks or lips or place pens, paperclips, fingernails etc. in your mouth? ☐Yes ☐No
Do you drink more than one cup of coffee a day or consume sweets, pop and / or add sugar in your coffee? ☐Yes ☐No
have you ever been told that you gasp for air in your sleep or been diagnosed with sleep apnea? ☐Yes ☐No

Do you expect to wear dentures someday? **☐Yes ☐No**
Are you missing teeth? **☐Yes ☐No If so, why?** _____

Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information we collect use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment via email and text.
- To send patients informational material about our dental practice.

Patient's Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment on all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to other health care professional for either a second opinion or treatment.

I, the undersigned, certify that to the best of my knowledge all the information I have provided today is correct. I have not knowingly omitted any information. I have had the opportunity to ask questions and received answers regarding my medical & dental history. Should there be any change in either my health status or personal information I have provided I will advise the office. I understand that all information is collected in strict confidence and is solely used to improve communications between this office and myself. **I authorize the dental staff to perform such dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company for legal documentation.**

I have read the above conditions of treatment and agree to their content. Date: _____/ _____ /_____
DD MM YYYY

✘_____ ✘_____ ✘_____

Print name **Signature** **Relationship (parent)**