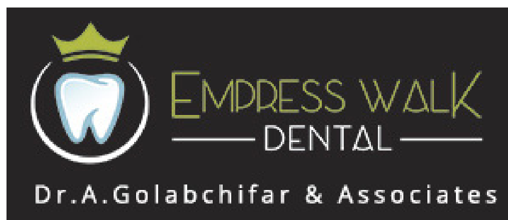

Welcome to our Practice

We look forward to becoming partners in your dental health care. Our approach to dentistry is prevention oriented and is a team effort involving you and our staff. Together we will address any current dental concerns and endeavor to prevent future dental problems.

Personal Information :

○ Dr. ○ Mr. ○ Ms. Last Name: ______ First Name: ______

Date Of Birth (mm/dd/yyyy) : ______ Sex: ○ M. ○ F.

Address: Street No. : ______ Street Name : ______ Apt. No. : ______

City: ______ Province: ______ Postal Code: ______

Phone Number: **Home:** ______ Work: ______ Ext. ______

Cell Phone: ______ **e-mail Address:** ______

Family Physician: ______ Phone Number: ______

Specialist: ______ Phone Number: ______

Occupation: ______ Employed by: ______

Who may we thank for referring you? ______

Family member (s) in our practice? ______

Financial Information :

Method of payment : ☐ Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other: ______

Person responsible for financial matters: ☐ ISelf ☐ Spouse ☐ Parent/Guardian ☐ Other: ______

Dental Insurance: ○ YES ○ NO

Insurance Co. Name: ______

Group Policy Number: ______ Certificate or ID Number: ______

Policy Holder's Name: ______ Date Of Birth (mm/dd/yyyy) : ______

Please proceed to page 2

Medical History : (All information gathered here, remains confidential)

(Please Select The Appropriate Answer to the Following Questions) **YES NO**

1. Are you in good health? .... ◯ ◯
2. When was your last complete medical examination?
3. Are you presently under the care of a physician? .... ◯ ◯

   If Yes, please explain :

4. Have you been hospitalized in the last 2 years? .... ◯ ◯
5. Are you taking any prescription or non-prescription medicines, regularly? .... ◯ ◯

   If yes, please Specify :

6. Do you have any allergies? i.e. drugs, asthma, skin rash, food allergies or latex. .... ◯ ◯

   Please Specify:

7. Have you ever had an adverse reaction to dental freezing? .... ◯ ◯
8. Do you have or have you ever had any of the following? ***(Please check all that apply)***

☐ Heart murmur, or other heart conditions	☐ Heart Attack	☐ Stroke	☐ Venereal Disease
☐ Stomach / intestinal problems	☐ Diabetes	☐ Cancer	☐ Sinus Trouble
☐ Mental or nervous disorders	☐ Drug addiction	☐ Herpes	☐ Liver diseases
☐ Epilepsy / Seizures / Rheumatism	☐ Kidney diseases	☐ AIDS	☐ Scarlet Fever
☐ joint replacement (hi, knee)	☐ Hypo / Hyper Glycemia	☐ Thyroid	☐ Rheumatic Fever
☐ High / Low blood pressure	☐ Jaundice Tuberculosis	☐ Arthritis	

Other:

Doctor's Notes:

9. Have you ever had any known contact with the AIDS virus? .... ◯ ◯
10. Do you bruise easily or bleed abnormally? .... ◯ ◯
11. Have you had any weight changes recently? .... ◯ ◯
12. Do you have any blood disorders such as anemia (thin blood)? .... ◯ ◯
13. Have you ever had any radiation or chemotherapy treatment? .... ◯ ◯

    If Yes, Please explain:

14. Have you ever had any injury, surgery, or x-ray therapy to your face or jaws? .... ◯ ◯
15. Do you have frequent severe headaches? .... ◯ ◯
16. Have you ever fainted? .... ◯ ◯
17. Do you ever experience shortness of breath or pain in your chest when walking or climbing stairs? ◯ ◯
18. Have you ever had any organ transplant or medical /dental implant? .... ◯ ◯

Please proceed to page 3

(Please Select The Appropriate Answer to the Following Questions) **YES NO**

19. Do you have any disease, condition, problem not listed above that you think the dentist should know about?

If Yes, Please explain:

Doctor's Notes:

WOMEN ONLY

20. Are you pregnant? ....

If Yes, how many months?

21. Are you taking any birth control pills? ....

IN ORDER TO AVOID COMPLICATIONS AS A RESULT OF A CHANGE IN YOUR MEDICAL CONDITION, IT IS VERY IMPORTANT THAT YOU NOTIFY OUR OFFICE OF THESE CHANGES AS SOON AS POSSIBLE.

Place any Extra Notes here :

Please proceed to page 4

Dental History :

(Please Select The Appropriate Answer to the Following Questions) **YES NO**

1. What has brought you to our office today?
2. Are you having any dental discomfort at this time? .... ◯ ◯

   Where?
3. How often do you visit your dentist?

   When was your last visit?
4. Are your gums bleeding? .... ◯ ◯

   When?
5. Have you ever had any of the following: (please check all that apply) ◯ ◯

   ☐ Bite Plate or other appliances ☐ Orthodontic Treatment ☐ Periodontal Treatment ☐ Oral Surgery

   ☐ Bite Adjustment Please Specify:
6. Do you have any dental implants? .... ◯ ◯
7. Do you suffer from pain and / or swelling of your gums? .... ◯ ◯
8. Do you chew on only one side of your mouth? .... ◯ ◯

   If Yes, why?
9. **HABITS:** Do you grind or clench your teeth during the day or night? .... ◯ ◯

   Mouth breathe while awake or asleep? .... ◯ ◯

   Bite your cheeks or lips regularly? .... ◯ ◯

   Hold any foreign objects with your teeth? i.e. pipe, pencils, nails .... ◯ ◯
10. Does any part of your mouth hurt when clenched? .... ◯ ◯
11. Does your jaw crack or pop when opened widely? .... ◯ ◯
12. Do you have pain in your ears? .... ◯ ◯
13. Have you ever experienced any growth or sore spots in your mouth? .... ◯ ◯

    If Yes where?
14. Are you concerned with the appearance of your teeth? .... ◯ ◯

    If Yes, what would you like to see changed?

Doctor's Notes:

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform diagnostic procedures including taking of X-rays and photographs may be required to determine necessary treatment. I also give my consent to the dentist to perform any treatment needed to improve my dental and oral health. I do realize that there are certain risk involve in performing dental procedures. Hereby I release the dentist and Empress Walk Dental Office from any liability should any unwanted event happens as a result of the said procedure. I understand that information provided from or to my medical doctor or another health care provider may be necessary.I have been advised of the privacy policy of the office and that my personal information may be collected, used and disclosed within the guidelines of the policy. I also give consent to give and get information regarding my insurance policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Signature: ______________________ Date: ______________

Reviewed by Treating Dentist: ______________________ Date: ______________