UPPER CANADA
Dental Centre

WELCOME TO OUR OFFICE

DATE _____

(FOR OFFICE USE ONLY)

I.D, #	
MEDICAL ALERT	

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. Please answer the questions as accurately as you can. If you have any questions or doubts, please ask the treating dentist or our receptionist, who is available to assist you with the completion of this form. All information is **strictly confidential** and will remain with this office.

PLEASE PRINT

REGISTRATION INFORMATION

The patient is an: Adult ☐ Child ☐ Adult under guardianship ☐ Guardian:_____

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Name: _____ _____

Address: _____ Birth Date: Mo. Day____Yr.____

Bus. Phone: ( ) _____ - _____ Home Phone ( ) _____ - _____

Age _____ Sex _____ Marital Status _____ May we call you at work? Yes ☐ No ☐

Employer:_____ Occupation:_____

Are other family members patients at our office?_____

Whom may we thank for referring you?_____

MEDICAL PRIORITY

Family Physician: _____ Phone ( ) _____

Are you under the care of a Medical Specialist? Yes ☐ No ☐ Type of Specialist: _____

_____ Phone ( ) _____

In case of emergency, please contact: _____ Phone ( ) _____

FINANCIAL INFORMATION

Person responsible for account: _____ Name of Spouse _____

Do you have insurance? Yes ☐ No ☐ Insurance Co. _____

Policy No._____ Certificate No._____ Ins. Year end_____ Ins. Phone No._____

Name of Subscriber:_____

Policy Holder: _____

Maximum Coverage: _____ Coverage for: Basic____% Major Rest.____% Other ____%

METHOD OF PAYMENT

(For Office Use Only) CASH ☐ CHEQUE ☐ CREDIT CARD ☐ OTHER ☐

HEALTH HISTORY

Patient's Name: _____ Date: _____

(Please ✔ Yes or No to each question. If unsure of a question, please consult with the dentist.)

	Yes	No
1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____	☐	☐
Has there been any change in your general health in the past year? _____	☐	☐
2. Have you been hospitalized in the past two years? _____	☐	☐
3. When was your last visit to a Physician? _____		
Last complete physical examination? _____		
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? If yes, please list: 1._____ 2. _____ 3. _____ 4. _____ 5. _____	☐	☐
5. Have you ever reacted adversely to any of the following? (please circle) ANTIBIOTICS - Penicillin, Sulfonamide, other antibiotics, ASPIRIN, BARBITURATES (sleeping pills) CODINE, DARVON, LOCAL ANAESTHETIC (freezing), NITROUS OXIDE, _____ any other medicine: _____	☐	☐
6. Have you ever been advised against taking any specific type of medication? _____	☐	☐
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies,	☐	☐
Skin Rashes, Hives, or any other allergic conditions? _____	☐	☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so please explain: _____	☐	☐
9. Has any family member had diabetes? _____	☐	☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____	☐	☐
11. Do your ankles, feet or hands swell? _____	☐	☐
12. Has your weight, appetite or energy level changed dramatically recently? _____	☐	☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
14. Do you follow a special diet? _____	☐	☐
15. Have you tested HIV positive? _____	☐	☐
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____	☐	☐
17. Have you ever had any injury or surgery to your face or jaws? _____	☐	☐
18. Do you wear eyeglasses or contact lenses? _____	☐	☐
19. Do you have any hearing difficulties? _____	☐	☐
20. Do you smoke or use any other forms of tobacco? _____	☐	☐
Are you wearing the transdermal nicotine patch? _____	☐	☐
21. Are you alcohol and/or drug dependent? _____	☐	☐
and, Have you received treatment? _____	☐	☐
22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD: _____	☐	☐

Yes	No		Yes	No		Yes	No	
☐	☐	A.I.D.S	☐	☐	Congential heart lesions	☐	☐	heart murmur
☐	☐	Anemia	☐	☐	Cortisone/steriod	☐	☐	Heart pacemaker
☐	☐	Angina pectoris	☐	☐	Diabetes	☐	☐	Heart rhythm disorder
☐	☐	Arthritis/rheumatism	☐	☐	Emphysema	☐	☐	Heart surgery
☐	☐	Artificial heart valve	☐	☐	Epilepsy or seizures	☐	☐	Hepatitis A
☐	☐	Artificial joints (hip, knee)	☐	☐	Fainting or dizzy spells	☐	☐	Hepatitis B
☐	☐	Blood disorders	☐	☐	Glandular disorders	☐	☐	Hepatitis C
☐	☐	Bronchitis	☐	☐	Glaucoma	☐	☐	Herpes
☐	☐	Cancer	☐	☐	Head/neck injuries	☐	☐	High/low blood pressure
☐	☐	Circulation Problems	☐	☐	Heart disease or attack	☐	☐	Hodgkins disease

Yes	No		Yes	No		Yes	No	
☐	☐	Hyper (Hypo) Glycemia	☐	☐	Medical implant	☐	☐	Thyroid disease
☐	☐	Hyertension	☐	☐	Psychiatric treatment	☐	☐	Tuberculosis
☐	☐	Jaundice	☐	☐	Radiation treatment	☐	☐	Ulcers
☐	☐	Kidney disease	☐	☐	Chemotherapy	☐	☐	Venereal disease
☐	☐	Liver disease	☐	☐	Rheumatic/Scarlet fever	☐	☐	Other_____
☐	☐	Lung disease	☐	☐	Sickle cell disease	☐	☐	Other_____
☐	☐	Malignant Hyperthermia	☐	☐	Sinus trouble	☐	☐	Other_____
☐	☐	Mental/nervous disorder	☐	☐	Stomach problems	☐	☐	Other_____
☐	☐	Mitral valve prolapse	☐	☐	Intestinal problems	☐	☐	
☐	☐	Organ transplant	☐	☐	Stroke	☐	☐	

23. Has the **CHILD PATIENT** ***recently*** had any of the following: (indicate approximate date)

☐	☐	Measles	☐	☐	Strep throat
☐	☐	Mumps	☐	☐	Tonsilitis
☐	☐	Chicken Pox	☐	☐	Other_____

24. **WOMEN ONLY** Are you pregnant or suspect you may be? ☐ ☐

If yes, what is the expected delivery date?_____ Are you taking birth control pills? yes ☐ no ☐

25. Do you currently have, or have you had in the past, any disease, condition or problem not listed above?
yes ☐ no ☐ _____

26. Is there anything else about your health we should be made aware of? _____

27. Do you wish to speak to the Doctor privately about any problem or medical condition? yes ☐ no ☐

NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

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. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents in mine, and I assume responsibility for fees associated with these services.

X_____ _____

☐ PATIENT ☐ PARENT ☐ GUARDIAN (PRINT NAME OF GUARDIAN)

Doctor's comments: _____

_____

_____

_____

_____

_____

_____

Reviewed by Treating Dentist:_____ Date: _____

DENTAL HISTORY

(Please ✔ Yes or No to each question. If unsure of a question, please consult with the dentist.)

Is there a dental problem you would like treated immediately? Yes No
Date of last dental cleaning: _____ last visit: _____ last X-rays: _____

	Yes	No
1. Have you been seeing a dentist regularly?	☐	☐
2. Have you ever had any of the following?		
- Periodontal treatment? (treatment of the gums)	☐	☐
- Orthodontic treatment? (to straighten or realign teeth)	☐	☐
- A bite plate or any other appliance?	☐	☐
- Your bit adjusted or teeth ground?	☐	☐
- Oral surgery (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?	☐	☐
If you answered "Yes" to the last question, who performed the surgery?	☐	☐
When was it done?	☐	☐
Are you being followed up by a dental specialist?	☐	☐
3. Are there any growths or sore spots in your mouth?	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?		
5. Have you noticed any loose teeth, or, have any of your teeth shifted?	☐	☐
6. Does food catch between your teeth?	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐	☐
8. Have you been advised to take antibiotics before a dental appointment?	☐	☐
9. Do you use dental floss, proxabrush or stimulants? How often?	☐	☐
10. How often do you brush your teeth?	☐	☐
11. Have you ever experienced any of the following jaw problems?		
- Popping / clicking in your jaw joints?	☐	☐
- Pain in your jaw joints, around the ear, or side of the face?	☐	☐
- Difficulty in opening or closing?	☐	☐
- Pain when teeth are clenched?	☐	☐
- Pain or difficulty while chewing?	☐	☐
12. Do you have any of the following habits?	☐	☐
- Clenching or grinding your teeth while awake or asleep?	☐	☐
- Biting your cheeks or lips?	☐	☐
- Mouth breathing while awake or asleep?	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)?	☐	☐
13. Do you have any emotional concerns about having dental treatment?	☐	☐
14. Are you dissatisfied with the appearance of your teeth?	☐	☐
and, What would you like to see changed?	☐	☐
15. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns?	☐	☐

_____

_____

Doctor's Comments: _____

_____