

Welcome to our office !

Thank you for choosing us for your dental care. We appreciate the opportunity to serve you and strive to provide you with the highest quality dental care in a relaxed atmosphere. Our goal is to help you achieve and maintain excellent dental health. The better we communicate, the better we can care for your needs. If you have any questions, we will be delighted to help you.

1. ABOUT YOU		
Surname : _____	Address : _____	
Name : _____	City : _____	
I prefer to be called : _____	Postal code : _____	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Common-law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Name of spouse / partner : _____		
Home # : _____	Work # _____	Mobile # _____
Email address : _____		Date of birth _____
Occupation : _____	Employed by : _____	How long : _____

In case of emergency, contact : _____
Relationship : _____ Phone number : _____

2. GETTING TO KNOW YOU	
Whom may we thank for referring you ? _____	
<input type="checkbox"/> Family / friend	<input type="checkbox"/> Google <input type="checkbox"/> Internet / Web site <input type="checkbox"/> Other, please specify _____

3. DENTAL INSURANCE	
PRIMARY INSURANCE	SECONDARY INSURANCE (if applicable)
Insurance co : _____	Insurance co : _____
Policy holder : _____	Policy holder : _____
Policy / Group # : _____	Policy / Group # : _____
Certificate / ID # : _____	Certificate / ID # : _____
Date of birth of policy holder : _____	Date of birth of policy holder : _____

CONSENT FOR TREATMENT	
1. I hereby authorize Dr. Brown and staff to take x-rays, study models, photos and other diagnostic aids deemed appropriate by Dr. Brown to make a thorough diagnosis of my dental needs.	
2. Upon such diagnosis, I authorize Dr. Brown to perform all recommended treatment mutually agreed upon.	
3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.	

OFFICE POLICY	
1. We see all patients on an appointment basis so that we can provide the proper amount of time for each person. We endeavour to see all patients on time and ask that you extend the same courtesy to us. We consider an appointment made to be an agreement and commitment between our office and our patients. If you are unable to keep an appointment, we require 2 business days' notice otherwise it will be necessary to charge for the time lost.	
2. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at time of service, unless other arrangements have been made. If payments are not received by the agreed upon dates, I understand a finance charge of 12% per annum will be added to my account.	

Patient signature _____

Date _____

4. DENTAL HISTORY

Are you experiencing any dental problems ? _____

Previous Dentist's name : _____ Date of last dental visit : _____

Date of last dental cleaning _____ Date of last full mouth x-rays _____

How often do you brush your teeth ? _____ How often do you floss? _____

What other dental aids do you use ? (electric, toothpick, etc.) _____

Are any of your teeth sensitive to :

Hot or cold ? Yes sometimes No

Sweets ? Yes sometimes No

Biting or chewing ? Yes sometimes No

Do your gums bleed or hurt ? Yes sometimes No

Do you get blisters, cold sores, any other oral lesions? Yes sometimes No

Are there any growths or sore spots in your mouth? Yes No

Have you ever had :

Orthodontic treatment (braces) ? Yes No

Root canal treatment ? Yes No

Periodontal (gum) treatment ? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard ? Yes No

Teeth extracted due to abscess, accident, decay or gum disease - *underline one(s)*? Yes No

Any problems after an extraction ? Yes No

A **serious** injury to the mouth or head ? Yes No
If so, please describe, including cause

Have you noticed :

Any mouth odours or bad tastes ? Yes No

Any loose teeth or change in your bite? Yes No

Does food tend to become caught between your teeth ? Yes No

If yes, where _____

Do you :

Bite your lips or cheeks regularly ? Yes No

Clench or grind your teeth ? Yes No

Breathe through your mouth ? Yes No

Have tired jaws, esp. in the morning? Yes No

Hold foreign objects with your teeth ? (pencils, pipe, pins, nails, fingernails) Yes No

Smoke / chew tobacco ? Yes No

Use street / recreational drugs ? Yes No

Have you experienced :

Clicking or popping of the jaw ? Yes No

Pain in your jaw joints, around ears, side of face ? Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Pain when teeth are clenched ? Yes No

Are you satisfied with your teeth's appearance ? Yes No

If no, explain : _____

Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern :

Have you ever had an upsetting dental experience? Yes No
If yes, please describe :

Is there anything else about having dental treatment that you would like us to know ? If yes, please describe :

5. MEDICAL HISTORY

Physician's name and address : _____

Phone number : _____ Last physical : _____

- 1. Are you being treated or have you been treated in the past two years for any medical condition ?..... Yes No
If yes, why? _____
- 2. Are you presently taking any medication, drugs or pills ? Yes No
If yes, please list name and dosage : _____
- 3. **Are you allergic to or made sick by penicillin, aspirin, codeine, sulpha or any drugs or medication ?** Yes No
- 4. Are you aware of having an allergic or adverse reaction to any substance ? Yes No
If yes, please list : _____
- 5. Have you ever been hospitalized for any illnesses or operations? Yes No
- 6. Do you bleed **excessively** from a cut or injury ? Yes No

7. Check any of the following which you have had or have at present:

- | | | | |
|--------------------------|----------------------------------|--------------------------------|--------------------------------|
| AIDS | Cold sores/ fever blisters | Heart pacemaker | Rheumatic fever |
| Allergies or hives | Congenital heart disease | Hemophilia | Scarlet fever |
| Anemia | Contact lenses | Hepatitis A (infectious) | Shortness of breath |
| Angina pectoris | Cortisone medicine | Hepatitis B (serum) | Sickle cell disease |
| Arthritis / Rheumatism | Diabetes | High blood pressure | Sinus trouble |
| Artificial heart valve | Diet (special / restricted) | High cholesterol | STD |
| Artificial joints | Drug/alcohol addiction | HIV positive | Stroke |
| Asthma | Epilepsy or seizures | Kidney trouble | Swelling (ankles, feet, hands) |
| Blood transfusion | Emphysema | Liver disease | Thyroid problems |
| Bruise easily | Fainting or dizzy spells | Mitral valve prolapse | Tuberculosis |
| Bypass surgery | Glaucoma | Nervousness / anxiousness | Tumours |
| Cancer | Hayfever | Neurological disorders | Ulcers |
| Chemotherapy / radiation | Herpes (of any type) | Osteoporosis | Yellow jaundice |
| Chest pain | Heart (surgery, disease, attack) | Pain in jaw joints | Sleep apnea |
| Chronic bronchitis | Heart murmur | Psychiatric/psychological care | |

Additional information / Other condition not listed, : _____

- 8. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs ? Yes No
- 9. Has your weight, energy level or appetite changed drastically recently ? Yes No
- 10. Are there any diseases/medical problems that run in the family (e.g. diabetes, cancer, heart disease)?..... Yes No
- 11. Do you get FREQUENT, SEVERE headaches, earaches, ear/throat infections ? Yes No
- 12. Do you have hearing difficulties? Yes No
- 13. Have you had a local anaesthetic (freezing) ? Yes No
- 14. Have you experienced any problems or complications with any type of anaesthetic? Yes No

15. WOMEN ONLY. Are you :
Pregnant/anticipate becoming pregnant? Yes ___ months No **On birth control?** Yes No _____

16. Has the **CHILD patient RECENTLY** had any of the following ?
 Chicken pox Measles Mumps Scarlet fever Strep throat Tonsillitis

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the Doctor of any change in my health or medication.

Signature of patient / guardian _____ Date _____

History review	
Dentist signature _____	Date _____