PERSONAL INFORMATION:

Title: _____ First Name: _____ Last Name: _____
Preferred Name: _____

Address: _____ City:
Province: _____ Postal Code:_____

Home #: _____ Cellular #: _____ Work #: _____

Email: _____

Contact Method: _____ Occupation: _____
Employer/School: _____

Emergency Contact: _____ Telephone #: _____ Emergency Relationship: _____

Date of Birth: year month day Gender: _____

Are you available for Short Notice Appointments? Yes ⬭ No ⬭

If you were referred to this office, by whom were you referred: _____

MEDICAL INFORMATION:

Dental professionals primarily treat the area in and around your mouth. Since your mouth is part of your body any medications you are taking as well as your medical history have an important relationship with your Dental Treatment, please answer the following questions:

- Are you seeing a Family Physician? Yes ⬭ No ⬭
  If so, please enter name, phone number and date of last visit.

- Have you recently (in the last two years) been hospitalized or had a major operation?
  Yes ⬭ No ⬭ Please explain.

- Have you ever had a serious head or neck injury? Yes ⬭ No ⬭ If so, please explain.

- For Women Only: Taking Birth control pills? Yes ⬭ No ⬭

- Are you or could you be pregnant? Yes ⬭ No ⬭
  If yes, what is the expected delivery date?

- AIDS/HIV Positive Yes ⬭ No ⬭
- Chest Pains Yes ⬭ No ⬭
- Hemophilia Yes ⬭ No ⬭
- Alzheimer's Disease Yes ⬭ No ⬭
- Circulation Problems Yes ⬭ No ⬭
- Hepatitis A Yes ⬭ No ⬭
- Anaphylaxis Yes ⬭ No ⬭
- Diabetes Yes ⬭ No ⬭
- Hepatitis B or C Yes ⬭ No ⬭
- Anemia Yes ⬭ No ⬭
- Emphysema Yes ⬭ No ⬭
- High Blood Pressure Yes ⬭ No ⬭
- Chemotherapy Yes ⬭ No ⬭
- Heart Surgery Yes ⬭ No ⬭
- Tuberculosis Yes ⬭ No ⬭
- Hypothyroidism Yes ⬭ No ⬭
- Hyperthyroidism Yes ⬭ No ⬭
- Endocrine Problems Yes ⬭ No ⬭
- Stroke Yes ⬭ No ⬭
- Arthritis/Gout Yes ⬭ No ⬭
- Epilepsy/Seizures Yes ⬭ No ⬭
- Kidney Problems Yes ⬭ No ⬭
- Artificial Heart Valve Yes ⬭ No ⬭
- Fainting Yes ⬭ No ⬭
- Liver Problems Yes ⬭ No ⬭
- Artificial Joint Yes ⬭ No ⬭
- Glaucoma Yes ⬭ No ⬭
- Lung Disease Yes ⬭ No ⬭
- Asthma Yes ⬭ No ⬭
- Head or Neck Injuries Yes ⬭ No ⬭
- Mental/Nervous Disorder Yes ⬭ No ⬭
- Blood Disease Yes ⬭ No ⬭
- Heart Attack/Failure Yes ⬭ No ⬭
- Organ/Medical Transplant Yes ⬭ No ⬭
- Bruise Easily Yes ⬭ No ⬭
- Heart Murmur Yes ⬭ No ⬭
- Sickle Cell Disease Yes ⬭ No ⬭
- Cancer Yes ⬭ No ⬭
- Heart Pacemaker Yes ⬭ No ⬭

List all drugs/medications you are taking (if you are taking more than four medications, please attach a separate list):

1) Name_____
Dosage_____
Frequency_____
Reason_____
2) Name_____
Dosage_____
Frequency_____
Reason_____

3)Name_____
Dosage_____
Frequency_____
Reason_____
4) Name_____
Dosage_____
Frequency_____
Reason_____

Are you allergic to or have you had a reaction to any of the following items?

- Barbiturates, sedatives, or sleeping pills Yes ⬭ No ⬭
- Nitrous Oxide Yes ⬭ No ⬭
- Aspirin Yes ⬭ No ⬭
- Codeine Yes ⬭ No ⬭
- Darvon Yes ⬭ No ⬭
- Local Anesthetic Yes ⬭ No ⬭
- Antibiotics Yes ⬭ No ⬭ If yes, please indicate the name of the antibiotic:_____
  Other:_____
- If you have ever been advised against taking any type of medication, please list them:
- If you have any allergic conditions, please list them. This can include asthma, hay fever, food allergies, and metal or latex allergies.
- Have you ever had any joint replacement surgery? Yes ⬭ No ⬭ If yes, please indicate type and date of the surgery
- Have you been told by your MD that you need to take premedication (antibiotics) one hour before your dental appointment? Yes ⬭ No ⬭ If yes, please indicate: Name of antibiotic_____ Reason for the prescription_____
- Do you use any form of Tobacco? Yes ⬭ No ⬭ If yes, number of cigarettes per day:_____ Number of years:_____
- Are wearing a nicotine patch? Yes ⬭ No ⬭
- Are you dependent on Alcohol or drugs? Yes ⬭ No ⬭
- Do you bruise easily, or bleed severely when you are cut? Yes ⬭ No ⬭
- Do you have severe earaches, ear or throat infections or headaches? Yes ⬭ No ⬭
- Do you wear glasses or contact lenses? Yes ⬭ No ⬭

DENTAL INFORMATION:

In the following sections, please select whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- Do your gums bleed while brushing or flossing? Yes ⬭ No ⬭
- Do you bite your lip or cheeks frequently? Yes ⬭ No ⬭
- Have you ever had Orthodontic (braces) treatments? Yes ⬭ No ⬭
- Do you have Headaches or Migraines? Yes ⬭ No ⬭
- Are your teeth sensitive to cold, hot, sweets or pressure? Yes ⬭ No ⬭
- Have you had any difficult extractions? Yes ⬭ No ⬭
- Do you feel pain to any of your teeth? Yes ⬭ No ⬭
- Ever worn a bite plate or other appliances? Yes ⬭ No ⬭
- Do you have any sores or lumps in or near your mouth? Yes ⬭ No ⬭

- Have you ever had difficulty opening or Have you ever had a head, neck or jaw injury? Yes ⬭ No ⬭

- Please enter details or any further information: _____

Please give a brief description of your Oral Hygiene Habits:

- If you have a current dental problem, please describe: _____
- Do you have any concerns about having Dental Treatment? If so, please explain. _____
- Are you happy with the appearance of your teeth? If no, please explain. _____
- Date of your last teeth cleaning: _____
- Date of your Last Dental Exam: _____

Office policy:

We will help prepare insurance claim forms and assist in requesting reimbursements from insurance companies on behalf of our patients. Not all services may be covered by dental insurance and every plan has its own unique quirks and exceptions. We will do our best to help you clarify your plan. However, it is the patient's responsibility to understand his or her own dental insurance benefits. Unless otherwise agreed upon, services are to be paid for at each visit as they are performed.

Please help us in providing the very best of service by remembering that once you have made an appointment this time is reserved for you. Therefore, we require a minimum of 48 hours notice (2 business days) if an appointment must be cancelled or rescheduled. A fee may be charged for cancelled or missed appointment without sufficient notice. A Please note that insurance companies do not cover fees for broken appointments. Therefore, such fees are the patient's responsibility.

I hereby certify the above information is true and accurate. I acknowledge that in an effort to enhance the patient experience as well as for educational and training purposes, Dental Art Clinic utilizes the use of photography as well as audio and video recording devices. The complete recordings and any information that could identify me will be kept confidential.

Signature: _____ Date: _____