

NEW PATIENT FORM

The following information is required by our office to thoroughly diagnose any condition and give you personal attention. This form is **STRICTLY CONFIDENTIAL**. *Please fill out the form completely.*

Personal Information

NAME		DATE OF BIRTH
ADDRESS		POSTAL CODE
HOME PHONE	CELL PHONE	EMAIL
OCCUPATION	EMPLOYER	WORK PHONE
HOW WOULD YOU LIKE TO BE CONTACTED? <i>(List in order, e.g. Cell, Work, Home, Email)</i>		PERSON RESPONSIBLE FOR YOUR ACCOUNT
IF CHILD, NAME OF MOTHER		IF CHILD, NAME OF FATHER

Dental Insurance

NAME OF INSURANCE PLAN	I.D. # or CERTIFICATE #	POLICY HOLDER'S EMPLOYER	DENTAL PLAN HOLDER'S NAME
POLICY OR PLAN NUMBER	DEPENDENT NUMBER	COVERAGE A B C Plan Max	PLAN HOLDER'S DATE OF BIRTH

Medical History

PERSONAL PHYSICIAN	SPECIALIST
CLINIC LOCATION	PHONE #

Do you have OR have you ever had *(Select all that apply)*

- | | | |
|--|---|--|
| <input type="checkbox"/> 1. hospitalization for illness or injury
<input type="checkbox"/> 2. an allergic reaction to:
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen
<input type="checkbox"/> penicillin
<input type="checkbox"/> erythromycin
<input type="checkbox"/> tetracycline
<input type="checkbox"/> codeine
<input type="checkbox"/> local anesthetic
<input type="checkbox"/> fluoride
<input type="checkbox"/> metals (gold, stainless steel)
<input type="checkbox"/> latex
<input type="checkbox"/> any other medications
_____ | <input type="checkbox"/> 3. to take antibiotics prior to a dental procedure
<input type="checkbox"/> 4. heart problems / defect / pacemaker
<input type="checkbox"/> 5. heart murmur / ventricular prolapse
<input type="checkbox"/> 6. rheumatic fever / scarlet fever
<input type="checkbox"/> 7. high blood pressure
<input type="checkbox"/> 8. low blood pressure
<input type="checkbox"/> 9. a stroke
<input type="checkbox"/> 10. artificial prosthesis <i>(e.g. joints, stents, heart valve)</i> Date: _____
<input type="checkbox"/> 11. anemia or other blood disorder
<input type="checkbox"/> 12. abnormal bleeding
<input type="checkbox"/> 13. emphysema
<input type="checkbox"/> 14. tuberculosis | <input type="checkbox"/> 15. asthma
<input type="checkbox"/> 16. breathing or sleep problems <i>(snoring, sinus, sleep apnea)</i>
<input type="checkbox"/> 17. sinus problems
<input type="checkbox"/> 18. kidney disease
<input type="checkbox"/> 19. liver disease
<input type="checkbox"/> 20. jaundice
<input type="checkbox"/> 21. thyroid or parathyroid disease
<input type="checkbox"/> 22. hormone deficiency
<input type="checkbox"/> 23. high cholesterol
<input type="checkbox"/> 24. diabetes <i>(circle):</i> Type 1 Type 2
<input type="checkbox"/> 25. stomach or duodenal ulcer
<input type="checkbox"/> 26. digestive disorders (gastric reflux)
<input type="checkbox"/> 27. eating disorders (anorexia/bulimia) |
|--|---|--|

Do you have OR have you ever had (select all that apply)

- ☐ 28. osteoporosis/osteopenia (taking bisphosphonates)
☐ 29. arthritis
☐ 30. glaucoma
☐ 31. contact lenses
☐ 32. head or neck injuries
☐ 33. epilepsy, convulsions (seizures)
☐ 34. neurologic problems / alzheimers / memory loss
☐ 35. viral infections and cold sores
☐ 36. any lumps or swelling in the mouth
☐ 37. dry mouth
- ☐ 38. hives, rash, hay fever
☐ 39. venereal disease
☐ 40. hepatitis (type _____)
☐ 41. HIV / AIDS
☐ 42. tumor, abnormal growth
☐ 43. radiation therapy
☐ 44. chemotherapy
☐ 45. emotional problems
☐ 46. psychiatric treatment
☐ 47. antidepressant medication
☐ 48. alcohol / drug dependency

Are you: (Select all that apply)

- ☐ 49. presently being treated for any other illness
☐ 50. aware of a change in your general health
☐ 51. often exhausted or fatigued
☐ 52. subject to frequent headaches
☐ 53. a smoker, smoked previously, use tobacco
☐ 54. Female – taking birth control pills
☐ 55. Female – pregnant /nursing
☐ 56. Male – prostate disorders

Additional Medical Information**List all medications, supplements, and/or vitamins taken within the last two years**

Medication

Reason for taking

Describe any medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.**Dental History**

REFERRED BY	PREVIOUS DENTIST	HOW LONG HAVE YOU BEEN A PATIENT?
DATE OF LAST DENTAL EXAM / CLEANING	DATE OF LAST DENTAL XRAYs	DATE OF LAST TREATMENT (eg. fillings, crowns, whitening)
I ROUTINELY SEE MY DENTIST EVERY (Select one only) <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> not routinely		HOW OFTEN DO YOU: BRUSH: _____ /day FLOSS: _____ /week BRUSH TONGUE: _____ /week
HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? (Select one only) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? (Briefly describe)

Dental History Details (*Select all that apply*)**Treatment History**

- ☐ Are you fearful of dental treatment?
- ☐ Have you had an unfavourable dental experience?
- ☐ Have you ever had complications from past dental treatment?
- ☐ Have you ever had trouble getting numb or reactions to local anesthetic?
- ☐ Did you ever wear braces, have orthodontic treatment or had your bite adjusted?
- ☐ Have you had any teeth removed?

Smile Characteristics

If you are not happy with the appearance and function of your teeth, what would you change?

- ☐ Whiter teeth
- ☐ Straighter teeth
- ☐ Close spaces
- ☐ Lengthen teeth
- ☐ Contour / reshape teeth
- ☐ Replace metal fillings
- ☐ Repair chipped / broken teeth
- ☐ Replace missing teeth
- ☐ Repair worn teeth
- ☐ Replace old crowns / caps that don't match

Gum, Bone, and Tooth Structure

- ☐ Are any teeth sensitive to hot, cold, biting, or sweets?
- ☐ Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?
- ☐ Do you feel or notice any holes (ie. Pitting) in your teeth?
- ☐ Have you ever been diagnosed or treated for periodontal (gum) disease?
- ☐ Have you ever experienced gum recession?
- ☐ Is there a history of periodontal disease in your family?
- ☐ Do your gums bleed when brushing, flossing, or eating?
- ☐ Are your teeth becoming loose?
- ☐ Have you ever noticed an unpleasant taste or odor in your mouth?
- ☐ Have you experienced a burning sensation in your mouth?

Bite and Jaw

- ☐ Do you have any problems chewing gum or hard foods?
- ☐ Have your teeth changed in the last 5 years, become shorter, thinner or worn?
- ☐ Are your teeth crowding or developing spaces?
- ☐ Do you have more than one bite or do you clench(squeeze) your teeth to make them fit together?
- ☐ Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
- ☐ Do you have tension headaches or sore teeth?
- ☐ Do you wear or have you ever worn a bite appliance? (night guard)

I hereby certify that the information given here is complete, true and correctly recorded, and I consent to examination and treatment agreed to be necessary or advisable.

Signature of Patient (or Parent / Guardian)

Date

Please submit this form to our staff at your convenience