HERITAGE DENTAL CENTRE

Submit Form

PERSONAL INFORMATION

Today's Date __ __ ____ (day mo. year)

Name: _____

Home Address: _____

Date of Birth __ __ ____ (day mo. year)

City: _____ Province: _____ Postal Code: _____

Tel: Home _____ Business: _____ Cell #: _____ Height: _____ Weight: _____

Employed By: _____ Occupation: _____

Email: _____ Name of Spouse: _____

Personal Physician: _____ Tel: _____

Whom may we thank for referring you? _____ Previous Dentist: _____

In case of emergency notify: Name: _____ Relationship: _____

Address: _____ Tel: _____

Dental Insurance Company: 1. _____ ID/Cert.#: _____ Policy/Group #_____

2. _____ ID/Cert.#: _____ Policy/Group #_____

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. ALL INFORMATION IS CONFIDENTIAL

	Yes	Don't Know / Maybe	No
1. Have you ever had a serious illness requiring hospitalization or extensive medical care?	☐	☐	☒
Specify: _____			
2. Are you presently under the care of a physician?	☐	☐	☐
If so, explain: _____			
3. Have you had a medical examination in the last year?	☐	☐	☒
4. Do you use any prescription or non-prescription medicine regularly?	☐	☐	☐
Specify: _____			
5. Do you have any allergic condition: ie. Asthma, hay fever, skin rash, food alergies?	☐	☐	☐
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea?	☐	☐	☐
Specify: _____			
7. Have you been hostpitalized in the last 5 years?	☐	☐	☐
8. Have you ever experienced any unusual reaction to any of the following? (please circle):	☐	☐	☐
local anaesthesia (freezing), aspirin, penicillin, iodine, sulfonamide, barbituates (sleeping pills), or any other medicine?			
If so, explain: _____			
9. Have you been warned against taking any drug or medication?	☐	☐	☐

10. Do you have or have you ever had any of the following? (Please check)

☐ Heart murmur or mitral valve prolapse	☐ Malignant hyperthermia	☐ AIDS	☐ Hepatitis A/B/C	☐ Liver Disease
☐ Stomach/intestinal problems	☐ Drug/alcohol addiction	☐ Positive testing for HIV virus	☐ Herpes	☐ Cortisone/Steroid
☐ Joint replacement (hip, knee, etc.)	☐ Venereal disease		☐ Heart attack	☐ therapy
☐ Mental or nervous disorder	☐ Any lung disease	☐ Jaundice	☐ Cold sores	☐ Other
☐ High/low blood pressure	☐ Thyroid disease	☐ Diabetes	☐ Cancer	_____
☐ Hyper (hypo) glycemia	☐ Arthritis or rheumatism	☐ Tuberculosis	☐ Kidney disease	_____
☐ Epilepsy or seizures	☐ Scarlet or rheumatic fever	☐ Stroke	☐ Sinus trouble	_____

	Yes	Maybe	No
11. Have you ever had any known contact with the AIDS virus?	☐	☐	☐
12. Has any member of your family had diabetes?	☐	☐	☐
13. Do you bruise easily or bleed abnormally?	☐	☐	☐
14. Do your ankles swell during the day?	☐	☐	☐
15. Have you had any weight changes recently?	☐	☐	☐
16. Do you have any blood disorders such as anemia (thin blood), thalassaemia (major, minor)?	☐	☐	☐
17. Have you ever had any radiation treatment or chemotherapy?	☐	☐	☐
If so, explain: _____			
18. Have you ever had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐	☐
19. Do you have frequent severe headaches?	☐	☐	☐
20. Do you have frequent earaches, ear/throat infections or any hearing difficulties?	☐	☐	☐
21. Is your eyesight: ☐ Good ☐ Adequate ☐ Poor Do your wear contact lenses?	☐	☐	☐
22. Are you on a special diet?	☐	☐	☐
23. Have you ever fainted?	☐	☐	☐

Medical History continued on other side

24. Do you ever experience shortness of breath or chest pain when walking or climbing stairs? ☐ ☐ ☐
If so, explain: _____
25. Have you had any organ transplants or medical implants? ☐ ☐ ☐
26. Do you have any disease, condition or problem that you think the doctor should know about? ☐ ☐ ☐
If so, explain: _____
27. Is there anything about yourself that we should be made aware of? ☐ ☐ ☐
If so, explain: _____
_____
28. WOMEN ONLY -Are you pregnant? If so, which month are you in? _____ ☐ ☐ ☐
-Are you taking any birth control pills? _____ ☐ ☐ ☐

TO AVOID COMPLICATIONS, PLEASE NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR MEDICAL CONDITION.

DENTAL HISTORY

1. Reason for today's visit: ☐Exam ☐Cleaning ☐Emergency ☐Other: _____
Is there a dental problem you would like to have taken care of as soon as possible? _____
_____
2. How frequently do you see your dentist? ☐6 Months ☐Yearly ☐Other _____
Former Dentist: _____ Last dental visit: _____
Last cleaning: _____ Last full mouth series of x-rays _____ X-rays requested _____
3. Have you been given oral hygiene instruction in: ☐Brushing ☐Flossing ☐Other _____ By whom? _____
4. Brushing: ☐ Vigorous ☐ Light How Often? _____ Type of brush? _____
5. How often do you floss your teeth? _____
6. Other cleaning aids used: ☐ Floss ☐Stimudents ☐Toothpick ☐Other _____
7. Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____
8. Do your gums bleed when: ☐Brushing ☐ Flossing ☐ Spontaneously
9. Is your sugar intake: ☐High ☐Medium ☐Low
10. Have you ever had or do you now have any of the following? (please check)

☐Bridges	☐Lost fillings	☐Bite appliance/night guard	☐Gum treatments
☐Partial dentures	☐Extractions	☐Swelling or pain in your	☐Gag easily
☐Full dentures	☐Loose teeth	mouth or jaws	☐Difficulty opening
☐Root canal fillings	☐Orthodontic treatment	☐Injuries to your face or jaws	or closing your jaw
☐Dental implants	☐Bite adjustment	☐Surgery in your mouth	

	Yes	Maybe	Don't Know / No
11. Do you chew on only one side of your mouth? If so, why? _____	☐	☐	☐
12. Does any part of your mouth hurt when clenched? _____	☐	☐	☐
13. Does your jaw crack or pop when opened widely? _____	☐	☐	☐
14. Do you Have any pain in your ears? _____	☐	☐	☐
15. Have you experienced any growth or sore spots in your mouth? If so, where? _____	☐	☐	☐
16. Do you? - grind or clench your teeth during the day or night? _____	☐	☐	☐
- mouth breathe while awak or asleep? _____	☐	☐	☐
- bite your lips or cheeks regularly? _____	☐	☐	☐
- hold any foreign objects in your teeth? (ie: Pipe, pencils, nails) _____	☐	☐	☐
- smoke? ☐Cigarettes ☐Cigars ☐Pipe ☐Other No. per day _____	☐	☐	☐

17. Check any of hte following you are interested in or you have thought about:

☐Orthodontics (braces)	☐Repairing chipped teeth	☐Improved gum health
☐Bonding (straightening)	☐Bleaching (whitening teeth)	☐Improving your bite
☐Closing spaces between teeth	☐Crowns (caps)	☐Improving breath odor
☐Replacing missing teeth	☐Sports mouth guard	☐Improving your smile

18. Would you rate your dental health as: ☐Excellent ☐Good ☐Fair ☐Poor
19. Do you have any emotional concerns regarding your dental visit? ☐Fear ☐Pain ☐Time ☐Money ☐Embarrassment
☐Other concerns _____
Comments: _____
_____

INFORMED CONSENT / GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services provided to me or my dependents.

Patient (Parent, Guardian) Signature: _____
If parent, guardian*, please print name: _____ Date: _____
M D Y

*Guardian of Child or Guardian of Adult under Guardianship