# NEW PATIENT FORM

*Welcome! Please complete all pages so that we may provide you with the best possible dental care.*

**All information is completely confidential.**

Given Name: Surname: Preferred Name:

Address: City:

Province: Postal Code: Date of Birth: Gender:

Home #: Mobile #: Occupation: Email:

Other Phone: Work #: Contact Method: Employee/School:

Marital Status: Name of Spouse: Emerg. Contact: Phone:

If you were referred to us, who referred you? Emerg. Relation:

## INSURANCE INFORMATION

### Primary Insurance

Subscriber Name: _____ Relationship: _____

Insurance Name: _____

Policy Number: _____ Policy Description: _____

Subscriber ID #: _____ Division Number: _____

Max. Coverage _____ % coverage: Basic _____ Major _____

Ortho _____ Scaling _____ Scaling units _____ Recall exam _____

### Secondary Insurance

Subscriber Name: _____ Relationship: _____

Insurance Name: _____

Policy Number: _____ Policy Description: _____

Subscriber ID #: _____ Division Number: _____

Max. Coverage _____ % coverage: Basic _____ Major _____

Ortho _____ Scaling _____ Scaling units _____ Recall exam _____

## DENTAL INFORMATION

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ Province_____ Postal code_____

How often do you have dental examinations? _____

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

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No

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

Do your gums bleed with brushing or flossing? Yes ☐ No ☐

Have you ever had Orthodonic (braces) Treatment? Yes ☐ No ☐

Are your teeth sensitive to cold, hot, sweets, or pressure? Yes ☐ No ☐

Do you feel pain to any of your teeth? Yes ☐ No ☐

Do you have any sores or lumps in your mouth? Yes ☐ No ☐

Have you ever had a head, neck, or jaw injury? Yes ☐ No ☐

Do you have any loose teeth or have they ever shifted? Yes ☐ No ☐

Do you feel that you have bad breath? Yes ☐ No ☐

Is the health of your gums and teeth important to you? Yes ☐ No ☐

Have you ever been advised to take antibiotics prior to dental treatment? Yes ☐ No ☐

If you have a current dental problem, please describe:

Do you have any other concerns about having dental treatment? If so, please explain Yes ☐ No ☐

Does food frequently get caught in your teeth? Yes ☐ No ☐

Do you bite your lips or cheeks frequently? Yes ☐ No ☐

Do you have headaches or migraines? Yes ☐ No ☐

Have you had any difficult extractions in the past? Yes ☐ No ☐

Ever worn a night guard or other appliance? Yes ☐ No ☐

Have you ever had difficulty opening or closing your jaw? Yes ☐ No ☐

Have you had any pain in your jaw area? Yes ☐ No ☐

Have you ever had Periodontal Treatment (gums)? Yes ☐ No ☐

Please give a brief description of your oral hygiene habits:

Do you ever feel nervous about visiting the dentist? If so, please explain Yes ☐ No ☐

Are you happy with the appearance of your teeth? If not, what would you like to see changed? Yes ☐ No ☐

# MEDICAL HISTORY

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? _____ ☐ Yes ☐ No
   Describe _____
2. Have you taken any medication or drugs during the past two years? _____ ☐ Yes ☐ No
3. Are you currently taking any medication, drugs, pills or herbal remedies? If Yes, please provide a list below_____ ☐ Yes ☐ No

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

4. Do you bleed excessively from a cut or injury, or bleed easily? _____ ☐ Yes ☐ No
5. Do you smoke, have you smoked in the past or used other forms of tobacco? _____ ☐ Yes ☐ No
6. Do you follow a special diet, or are you on a diet pill therapy? _____ ☐ Yes ☐ No
7. Do you have any hearing difficulties? _____ ☐ Yes ☐ No
8. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? _____ ☐ Yes ☐ No
9. Are you aware of having an allergic (or adverse) reaction to any substance or medication? _____ ☐ Yes ☐ No
   If yes, please specify _____
10. Have you been a patient in the hospital during the past five years? _____ ☐ Yes ☐ No
11. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | ☐ Yes ☐ No | Kidney Trouble | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Chest Pain | ☐ Yes ☐ No | Ulcers | ☐ Yes ☐ No | AIDS/HIV Positive | ☐ Yes ☐ No |
| Congenital Heart Disease | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Cold Sores/Fever Blisters | ☐ Yes ☐ No |
| Heart Murmur | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No | Blood Transfusion | ☐ Yes ☐ No |
| High/Low Blood Pressure | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Hemophilia | ☐ Yes ☐ No |
| Mitral Valve Prolapse | ☐ Yes ☐ No | Contact Lenses | ☐ Yes ☐ No | Sickle Cell Disease | ☐ Yes ☐ No |
| Artificial Heart Valve/ Pacemaker | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | Bruise Easily | ☐ Yes ☐ No |
| Rheumatic Fever | ☐ Yes ☐ No | Chronic Cough | ☐ Yes ☐ No | Liver Disease/Yellow Jaundice | ☐ Yes ☐ No |
| Arthritis/Rheumatism | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No | Neurological Disorders | ☐ Yes ☐ No |
| Cortisone Medicine | ☐ Yes ☐ No | Asthma | ☐ Yes ☐ No | Epilepsy or Seizures | ☐ Yes ☐ No |
| Swollen Ankles | ☐ Yes ☐ No | Hay Fever/Allergy/Hives | ☐ Yes ☐ No | Fainting or Dizzy Spells | ☐ Yes ☐ No |
| Stroke | ☐ Yes ☐ No | Latex Sensitivity | ☐ Yes ☐ No | Nervous/Anxious | ☐ Yes ☐ No |
| Diet (Special/Restricted) | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No | Psychiatric/Psychological Care | ☐ Yes ☐ No |
| Artificial Joints (Hip, Knee, etc.) | ☐ Yes ☐ No | Radiation Therapy | ☐ Yes ☐ No | Hepatitis A, B | ☐ A ☐ B ☐ No |
| | | Chemotherapy | ☐ Yes ☐ No | Hepatitis C | ☐ Yes ☐ No |
| | | Tumors | ☐ Yes ☐ No | | |

10. Have you lost or gained more than 10 pounds in the last year? _____ ☐ Yes ☐ No
11. Do you have or have you had any disease, condition, or problem not listed? If yes, please describe_____ ☐ Yes ☐ No
    _____
12. Women: Are you pregnant or think you could be pregnant? ☐ Yes____ Months ☐ No Nursing? ☐ Yes ☐ No
13. Do you use birth control prescriptions? _____ ☐ Yes ☐ No

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify your office of any change in my health or medications.

Patient / Guardian Signature _____ Date _____