WELCOME TO OUR OFFICE

Date: _____

Name: _____ Date of Birth_____/_____/_____

Address _____

City _____Province_____Postal Code _____

Telephone: Residence _____ Business _____Cell _____

Email Address: _____ Occupation Employer _____

Whom may we thank for referring you? _____Person Responsible for Account _____

Do you have Dental Insurance? ☐Yes☐ No

Primary Dental Insurance

Name of Insured:_____ Date of Birth_____/_____/_____

Employer: _____

Insurance Carrier: _____ Group/Policy Number _____

Div: _____ I.D. Number _____ Certificate Number _____

Coverage Percentage A___ B____ C____ D_____

Limits: Basic _____ Major _____ Ortho _____

Deductible: Basic _____ Major _____ Per person _____ Per Family____

Secondary Dental Insurance

Name of Insured:_____ Date of Birth_____/_____/_____

Employer: _____

Insurance Carrier: _____ Group/Policy Number _____

Div: _____ I.D. Number _____ Certificate Number _____

Coverage Percentage A___ B____ C____ D_____

Limits: Basic _____ Major _____ Ortho _____

Deductible: Basic _____ Major _____ Per person _____ Per Family____

HEALTH QUESTIONNAIRE

Name: _____ Date of Birth Month _____ / Day _____ / Year _____

To help ensure your well-being while receiving treatment in our office, please answer the following questions. All information will be considered confidential and for our records only.

General

1. Have you been examined and/or treated by a physician within the last year? ☐Yes ☐No
   Physician's Name _____ Physician's Phone _____
2. Have you ever been seriously ill or hospitalized or had major surgery? ☐Yes ☐No
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? ☐Yes ☐No
4. Are you taking any medications or non-prescription drugs now? ☐Yes ☐No
   What? _____

Please check if you have or have had any of the following?

SPECIFIC

☐Rheumatic Fever
☐Heart Murmur
☐Congenital heart condition
☐Heart attack
☐Arteriosclerosis
☐Blood pressure problems
☐Angina
☐Lung/breathing problems
☐Kidney/bladder problems
☐Stomach/intestinal problems

SENSITIVITIES/ALLERGIES:

☐Hives/skin rash
☐Asthma
☐Other Allergies/Sensitivities

SYSTEMS REVIEW:

☐Prolonged bleeding after injury
☐Bruise easily
☐High risk group for AIDS
☐Severe headaches
☐Sinus trouble
☐Sore throats
☐TMJ problems
☐Earaches
☐Trouble hearing

HABITS:

☐Tobacco
☐Non-prescription drugs
☐Alcoholic beverages (Alcoholism)
☐Drug Use Addiction

☐Diabetes ☐Type 1 ☐Type 2
☐Blood disorders
☐Pacemaker/artificial valves
☐Artificial joints/implants
☐Infectious/communicable disease
☐Cancer
☐Tumors or growths
☐Arthritis
☐Epilepsy
☐Thyroid Disease
☐Alzheimers/Dementia
☐Latex
☐Drug Allergies
☐Local Anesthetic
☐Shortness of breath
☐Blood in sputum
☐Recent change of appetite
☐Foods that you cannot eat
☐Difficulty in swallowing
☐Frequent indigestion/vomiting
☐Feel thirsty much of the time
☐Urinate more than 6 times/day
☐Painful, swollen joints
☐Numb/prickling sensations

WOMEN ONLY: Are you

☐Pregnant (how many months)
☐Past menopause

☐Stroke
☐Sleep Apnea
☐Vertigo
☐AIDS
☐Positive testing for HIV virus
☐Cortisone/steroid therapy
☐Depression
☐Liver disease
☐Inflammatory rheumatism
☐Jaundice
☐Hepatitis ☐A ☐B ☐C
☐Hay fever
☐Mental Health Condition
☐Anxiety
☐Autism
☐Persistent Cough
☐History of family disease
☐Acid Reflux
☐Swollen ankles
☐Heart palpitations
☐Fits, seizures or convulsions
☐Tendency to faint
☐Chest pains
☐History of broken bones/Osteoporosis
☐Cold sores
☐Physical disability
☐Chronic Fatigue Syndrome
☐Fibromyalgia/Lupus

Is there anything else concerning your health that you think the doctor should know about? ☐Yes ☐No
Do you need to take Antibiotic Premedication before dental work or hygiene appointment? ☐Yes ☐No

TREAMENT AUTHORIZATION

I, the undersigned, consent to the dental treatment agreed upon and that I am responsible for payment of the corresponding fees. I understand that a possibility of complications exists for each treatment. I give permission for the office to submit claims to my insurance company and to release dental records to another dental professional for any necessary treatment regarding my oral health.

Date: _____ Signature _____

☐Patient ☐Parent ☐Guardian

Name: _____ Date: _____

DENTAL HISTORY

Date of last dental visit _____ Former Dentist _____

Purpose _____

Have you had regular dental care (annually) in the past? ☐Yes ☐No

Do you have any oral habits such as clenching, grinding your teeth, or nail biting? ☐Yes ☐No

Have you ever had tooth brushing instruction? ☐Yes ☐No

How often do you brush your teeth? _____

Have you ever had instruction in using dental floss? ☐Yes ☐No

How often do you floss your teeth? _____

Are you satisfied with the function and appearance of your teeth? ☐Yes ☐No

Have you ever had or do you now have any of the following:

☐Bridges	☐Extractions	☐Gum treatments
☐Partial dentures	☐Loose teeth	☐Surgery in your mouth
☐Full dentures	☐Orthodontic treatment	☐Sensitive teeth
☐Root canal fillings	☐Swelling in your mouth or jaws	☐Bleeding gums
☐Lost fillings	☐Injuries to your face or jaws	☐Sores or lumps in mouth

What dental condition concerns you now? _____

_____

TREAMENT AUTHORIZATION

I, the undersigned, consent to the dental treatment agreed upon and that I am responsible for payment of the corresponding fees. I understand that a possibility of complications exists for each treatment. I give permission for the office to submit claims to my insurance company and to release dental records to another dental professional for any necessary treatment regarding my oral health.

Date: _____ Signature_____

☐Patient ☐Parent ☐Guardian

CLINICAL Examination

VITAL SIGNS: B.P. _____ temp. _____ Pulse Resp _____

EXTRAORAL: _____

INTRAORAL:

Tongue _____ Palate _____ Lips _____ Tonsils _____

Floor of mouth _____ Pharynx _____ Tori _____

Buccal mucosa _____

Comments: _____

ORAL HYGIENE: CALCULUS:☐ Light ☐Medium ☐Heavy ☐E☐ G☐ F☐ P ☐Supragingival ☐Subgingival

PERIODONTAL TISSUES:

☐Normal colour ☐Abnormal colour ☐Inflammation ☐Hemorrhage

Diagnosis: ☐Gingivitis ☐Periodontitis (Mild – moderate) ☐Periodontitis (Moderate–severe)

OCCLUSION:

Class _____ Max.Opening_____ Overjet _____ Overbite _____ CR to CO_____

TMJ: ☐Creptitus ☐Clicking/popping ☐Pain

NOTES:

_____

_____