



New Patient Information - Confidential

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called _____ [] Male [] Female

[] Single [] Married [] Child [] Other Birth date: d____/m____/y____ Age: _____

Home Address: _____ City _____ Province ____ Postal Code _____

Home Phone: (____) _____ Work: (____) _____ ext. ____ Cell: (____) _____

E-mail Address: _____

Employer: _____ How long there? _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: (____) _____ Work: (____) _____ ext. ____ Cell: (____) _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Company Name: _____ Phone: (____) _____

Insured's Name: _____ Insured's Birth date: d____/m____/y____

Group/Policy #: _____ Insured's ID/ Certificate #: _____

Insured's Employer: _____

Secondary Insurance

Insurance Company Name: _____ Relationship: _____

Insured's Name: _____ Insured's Birth date: d____/m____/y____

Group/Policy #: _____ Insured's ID/ Certificate #: _____

Insured's Employer: _____

MEDICAL HISTORY

Patient Name _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			32. neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulpham			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	42. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
7. artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	43. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	44. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>			
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>			
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>			
13. emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>			
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>			
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>			
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>			
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>			
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>			
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>			
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>			
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>			
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

ARE YOU:

45. presently being treated for any other illness _____		
46. aware of a change in your general health _____		
47. taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
48. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
49. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
50. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
51. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
52. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
53. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
54. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>

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

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS



7. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES NO
10. Have you been disappointed with the appearance of previous dental work? _____ YES NO

BITE AND JAW JOINT



11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
12. Do you / would you have any problems chewing gum? _____ YES NO
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ YES NO
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
15. Are your teeth crowding or developing spaces? _____ YES NO
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
17. Do you clench your teeth in the daytime or make them sore? _____ YES NO
18. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
19. Do you wear or have you ever worn a bite appliance? _____ YES NO

TOOTH STRUCTURE



20. Have you had any cavities within the past 3 years? _____ YES NO
21. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
22. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
23. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ YES NO
24. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
25. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
26. Do you get food caught between any teeth? _____ YES NO

GUM AND BONE



27. Do your gums bleed when brushing or flossing? _____ YES NO
28. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
29. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
30. Is there anyone with a history of periodontal disease in your family? _____ YES NO
31. Have you ever experienced gum recession? _____ YES NO
32. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ YES NO
33. Have you experienced a burning sensation in your mouth? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____