PATIENT INFORMATION

FIRST NAME: ______________ INITIAL: ______ LAST NAME: ______________

ADDRESS: ______________________________

CITY: ______________ PROVINCE: ______________ POSTAL CODE: ______________

BIRTHDATE (D/M/Y): __________ OCCUPATION: ______________ EMPLOYER: ______________

HOME PHONE: ______________ WORK PHONE: ______________ CELL PHONE: ______________

EMAIL ADDRESS: ______________________________ GENDER (M/F): __________

EMERGENCY CONTACT NAME: ______________ RELATIONSHIP: __________ PHONE: __________

PHYSICIAN NAME: ______________ PHONE: ______________ HEALTH CARE NUMBER: __________

PATIENT INFORMATION

PRIMARY INSURANCE PLAN

HOLDER'S FULL NAME: ______________ BIRTHDATE (D/M/Y): ______________

NAME OF INSURANCE CO.: ______________________________

GROUP/PLAN NUMBER: ______________ CERTIFICATE/ID NUMBER: ______________

SECONDARY INSURANCE PLAN

HOLDER'S FULL NAME: ______________ BIRTHDATE (D/M/Y): ______________

NAME OF INSURANCE CO.: ______________________________

GROUP/PLAN NUMBER: ______________ CERTIFICATE/ID NUMBER: ______________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________________

IS ANOTHER FAMILY MEMBER A PATIENT IN OUR OFFICE? ______________________________

BrentwoodDentalCentre DENTAL HISTORY

PATIENT NAME: ______________________ NICKNAME: ______________________ AGE: ________

REFERRED BY: ______________ HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

PREVIOUS DENTIST: ______________________ HOW LONG HAVE YOU BEEN A PATIENT? ____________ MOS/YRS

DATE OF MOST RECENT DENTAL EXAM: ____/____/____ DATE OF MOST RECENT X-RAYS: ____/____/____

DATE OF MOST RECENT TREATMENT (OTHER THAN CLEANING) ____/____/____

I ROUTINELY SEE MY DENTIST EVERY: ☐3 MO. ☐6 MO. ☐12 MO. ☐NOT ROUTINELY

WHAT IS YOUR IMMEDIATE CONCERN? ______________________________________

ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful on a sale of 1 (least) to 10 (most) ________	☐	☐
2. Have you had an unfavorable dental experience? ________	☐	☐
3. Have you ever had complications from past dental treatment? ________	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ________	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ________	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ________	☐	☐
GUM AND BONE	**YES**	**NO**
7. Do your gums bleed or are they painful when brushing or flossing? ________	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ________	☐	☐
10. Is there anyone with a history of periodontal disease in your family? ________	☐	☐
11. Have you ever experienced gum recession? ________	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ________	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ________	☐	☐
TOOTH STRUCTURE	**YES**	**NO**
14. Have you had any cavities within the past 3 years? ________	☐	☐
15. Does the amount of saliva in your mouth seem to little or do you have difficulty swallowing any food? ________	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ________	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? ________	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________	☐	☐
20. Do you frequently get food caught between any teeth? ________	☐	☐
BITE AND JAW JOINT	**YES**	**NO**
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ________	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ________	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ________	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ________	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ________	☐	☐
26. Are your teeth developing spaces or becoming more loose? ________	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ________	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? ________	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore? ________	☐	☐
31. Do you have any problems with sleep (i.e. restless or teeth grinding), wake up with a headache or an awareness of your teeth? ________	☐	☐
32. Do you wear or have you ever worn a bite appliance? ________	☐	☐
SMILE CHARACTERISTICS	**YES**	**NO**
33. Is there anything about the appearance of your teeth that you would like to change? (shape, color, size)? ________	☐	☐
34. Have you ever whitened (bleached) your teeth? ________	☐	☐
35. Have you ever felt comfortable or self conscious about the appearance of your teeth? ________	☐	☐
36. Have you been disappointed with the appearance of previous dental work? ________	☐	☐

PATIENT'S SIGNATURE: ______________________________ **DATE:** ____________

DOCTOR'S SIGNATURE: ______________________________ **DATE:** ____________

BrentwoodDentalCentre

MEDICAL HISTORY

PATIENT NAME: ______________________ NICKNAME: ______________________ AGE: ________

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
1. Hospitalization for illness or injury ____________	☐	☐
2. An allergic or bad reaction to any of the following:	☐	☐
☐ Aspirin, ibuprofen, acetaminophen, codeine		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Sulfa		
☐ Local anesthetic		
☐ Fluoride		
☐ Chlorhexidine (CHX)		
☐ Metals (nickel, gold, silver, __________)		
☐ Latex ____________________		
☐ Nuts ____________________		
☐ Fruit ____________________		
☐ Other ____________________		
3. Heart problems, or cardiac stent within the last six months	☐	☐
4. History of infective endocarditis	☐	☐
5. Artificial heart valve, repaired heart defect (PFO)	☐	☐
6. Pacemaker or implantable defibrillator	☐	☐
7. Orthopedic implant (joint replacement)	☐	☐
8. Rheumatic or scarlet fever	☐	☐
9. High or low blood pressure	☐	☐
10. A stroke (taking blood thinners)	☐	☐
11. Anemia or other blood disorder	☐	☐
12. Prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. Pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14. Chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15. Asthma	☐	☐
16. Breathing or sleeping problems (e.g. sleep apnea, snoring, sinus)	☐	☐
17. Kidney disease	☐	☐
18. Liver disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. Hormone deficiency	☐	☐
22. High cholesterol or taking statin drugs	☐	☐
23. Diabetes (HbA1c=__________)	☐	☐
24. Stomach or duodenal ulcer	☐	☐
25. Digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia)	☐	☐

	YES	NO
26. Osteoporosis/osteopenia (e.g., taking bisphosphonates)	☐	☐
27. Arthritis	☐	☐
28. Autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. Glaucoma	☐	☐
30. Contact lenses	☐	☐
31. Head and neck injuries	☐	☐
32. Epilepsy, convulsions (seizures)	☐	☐
33. Neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. Viral infections and cold sores	☐	☐
35. Any lumps or swelling in the mouth	☐	☐
36. Hives, skin rash, hay fever	☐	☐
37. STI/STD/HPV	☐	☐
38. Hepatitis (type ________)	☐	☐
39. HIV/AIDS	☐	☐
40. Tumor, abnormal growth	☐	☐
41. Radiation therapy	☐	☐
42. Chemotherapy, immunosuppressive medication	☐	☐
43. Emotional difficulties	☐	☐
44. Psychiatric treatment	☐	☐
45. Antidepressant medication	☐	☐
46. Alcohol/recreational drug use	☐	☐

ARE YOU:	YES	NO
47. Presently being treated for any other illness	☐	☐
48. Aware of a change in your health in the last 24 hours	☐	☐
(e.g. fever, chills, new cough, or diarrhea)	☐	☐
49. Taking medication for weight management	☐	☐
50. Taking dietary supplements	☐	☐
51. Often exhausted or fatigued	☐	☐
52. Experiencing frequent headaches	☐	☐
53. A smoker, smoked previously or use smokeless tobacco	☐	☐
54. Considered a touchy/sensitive person	☐	☐
55. Often unhappy or depressed	☐	☐
56. Taking birth control pills	☐	☐
57. Currently pregnant	☐	☐
58. Diagnosed with a prostate disorder	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen Injections) ______________________________

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

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:** ______________