DATE /D /M /Y

WELCOME TO OUR DENTAL OFFICE

URBAN DENTAL
CENTRE DENTAIRE

The information that is requested on this Questionaire, Dental History and Medical History is essential to providing you with the highest standard of dental care.
The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibiliy. PLEASE PRINT.

ADULT PATIENT or (Parent Guardian) REGISTRATION Dr___ Mr.___ Mrs.___ Ms.___ Mss___ Other ___

Are you the ____ Patient _____ Parent__ Guardian

Name _____ ____
(Last) (First) Initial

Address _____ _____ _____
Street City Province Postal code

Date of Birth _____ ___ Age ___ Sex ___ Marital Status Home phone _____
D M Y Cellphone _____
Email _____

Referring Dr. _____ Phone _____

Family Phisician _____

Address _____ _____ _____
Street City Province Postal code

Medical Specialist Phone

CHILD REGISTRATION or ADULT UNDER GUARDIANSHIP (if appicable)

Name _____ ____
(Last) (First) Initial

Address _____ _____ _____
(If different from above) Street City Province Postal code

Date of Birth _____ ___ Age ___ Sex ___ Marital Status Home phone _____

Person responsible for account ____ Self ___ Spouse ____ Other

Method of Payment ____ Cash ___ Cheque ____ Credit Card

Name _____ ____
(if differenct than self) (Last) (First) Initial

Address _____ _____ _____
Street City Province Postal code

Date of Birth _____ ___ Age ___ Sex ___ Marital Status Home phone _____

Spouse's name _____ Occupation _____

Employer _____ Phone _____

In Case of emergency _____ Phone _____

Closest family relative Phone

Is another family member or relative a patient at our office ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE

NAME OF INSURED _____ DOB _____
M D Y

EMPLOYER _____

INSURANCE CARRIER _____

GROUP/ POLICY NUMBER _____

CERTIFICATE NUMBER

SECONDARY DENTAL INSURANCE

NAME OF INSUREC _____ DOB _____
M D Y

EMPLOYER _____

INSURANCE CARRIER _____

GROUP/ POLICY NUMBER _____

CERTIFICATE NUMBER

PID:

DATE /D /M /Y

WELCOME TO OUR DENTAL OFFICE

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment

	Yes	Maybe	No
1- Have you ever had a serious illness requiring hospitalization or extensive medical care?	☐	☐	☐
2- Are you presently under the care of a physician?	☐	☐	☐
If so, explain: _____			
3- Have you been hospilatized in the last 5 years?	☐	☐	☐
4- Have you had a medical examination in the last year?	☐	☐	☐
5- Do you us any prescription or non-prescription medicine (including herbal remedies) regularly?	☐	☐	☐
Specify: _____			
6- Do you have any allergic conditions: i.e. asthma, hay fever, skin rash, food allergies, metal or latex allergies?	☐	☐	☐
7- Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea?	☐	☐	☐
If so, explain: _____			
8- Have you ever experienced any unusual reactions to any of the following? (please circle)	☐	☐	☐
Local anaesthesia (freezing) Aspirin, penicillin, iodine, sulfonamide, barbituartes (sleeping pills) or any other medication			
If so, explain: _____			
9- Have you been warned against taking any drugs or medications?	☐	☐	☐

10- Do you have or have you ever had any of the following? (Please mark with a x)

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

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), or thalassaemi (major, minor)?	☐	☐	☐
17- Have you ever had 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 you wear contact lenses?	☐		☐
22- Are you on a special diet?	☐		☐
23- Have you ever fainted?	☐	☐	☐
24- Do you ever experience shortness of breat or chest pain when walking or climbing stairs?	☐	☐	☐
If so, explain _____			
25- Have you had any organ transplnats 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, expain _____			
28- WOMEN ONLY, are you pregnant? If so, which month are you in? _____	☐		☐
Are you taking any birth control pills?	☐		☐

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WELCOME TO OUR DENTAL OFFICE

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 seris 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 uses: ☐ 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 folowing? (Please check)

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

	Yes	Maybe	No
11- Do you chew on only one side of your mouth? If so why? _____	☐	☐	☐
12- Does any part of your mout 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 breath while awake or asleep? ☐ Both ☐ Awake ☐ Asleep			
- Bite your lips or cheeks regularly?	☐		☐
- Hold any foreign objects with your teeth (i.e. pipe, pencils, nails)	☐		☐
- Smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other: _____ No. per day: _____			

17- Check (x) any of the following your 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 current 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 _____

GENERAL RELEASE

I, the undersigned, certify that I hve provided an accurate and complete personal and medical dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental servies for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

x _____ _____
(signature) Print Name of Patient

MEDICAL HISTORY UPDATE

DATE	SAME	CHANGE	PATIENT SIGNATURE	DR. INITIALS

If change, record in medical history

DATE	SAME	CHANGE	PATIENT SIGNATURE	DR. INITIALS

PID: