Welcome Dartmouth Dental Centre

We would ask that you complete the following confidential questions. We would be glad to assist you. PLEASE PRINT.

Patient Information A parent or guardian will be responsible for decisions on my treatment ☐Yes ☐No

Name: _____
First Initial Last

Gender M / F Date of Birth ____/____/____
D M Y

Address: _____
Street Apt. City Prov. Postal Code

Email: _____

Home Tel. (____) _____ Work Tel. (____) _____ Mobile (____) _____

Health #: _____ Expires. _____

Emergency Contact: _____ Tel. (____) _____

Who may we thank for your referral? _____

Family Doctor: _____ Tel. (____) _____

Occupation and Employer _____

Financial Information

Method of payment: Cash☐ Debit☐ Credit Card☐ Insurance☐ Other☐

Person responsible for financial matters: Self☐ Spouse☐ Parent/Guardian☐ Other☐

Dental History

1. What is the reason for today's visit? _____

2. How frequently do you see a dentist? ☐3-6 months ☐Annually
☐Other _____

3. When was your last dental visit? _____

4. Are your teeth sensitive to: ☐Cold ☐Sweets ☐Heat ☐Other

5. Do your gums bleed when: ☐Brushing ☐Flossing **YES** **NO**

6. Do your gums feel swollen or tender? ☐ ☐

7. Are you aware of any loose teeth? ☐ ☐

8. Do you have bad breath or a bad taste in your mouth? ☐ ☐

9. Do your jaws crack, pop or grind when you open widely? ☐ ☐

10. Do you grind or clench your teeth? ☐ ☐

11. Are you active in contact sports? ☐ ☐

12. Do you smoke? How much per day? ☐ ☐

13. Have you ever had any of the following: ☐Bridgework ☐Crowns or Caps ☐Root Canal
☐Full or Partial Dentures ☐Orthodontic (braces)
☐Periodontal (Gum)Treatment ☐Implants

14. Are you satisfied with your teeth? Specify _____ ☐ ☐

15. Are you tense during dental visits? ☐ ☐

16. Are you interested in a method to calm your nerves? ☐ ☐

CONTINUE ON BACK

Medical History (this information will remain confidential)

Date _____

		YES	NO
1.	Are you receiving ongoing medical care?	☐	☐
	Please specify _____		
2.	Are you taking any drugs or medications at this time?	☐	☐
	Please specify _____		
3.	Have you ever had any adverse effect or allergies to any of the following:	☐	☐
	Antibiotic - Penicillin ☐, Sulfonamide ☐, Other ☐, _____ **Aspirin** ☐: **Codeine** ☐:		
4.	Have you ever been warned against using any other medications?	☐	☐
	Which? _____		
5.	Have you been told you require antibiotics before dental treatment?	☐	☐
6.	Have you ever taken prolonged medical or non-medical drugs?	☐	☐
	Which? _____		
7.	Do you suffer from any allergies (hay fever, latex, etc.)? Which? _____	☐	☐
8.	Have you ever been hospitalized? If so, why _____	☐	☐
9.	Do you bruise easily or have prolonged bleeding?	☐	☐
10.	Have you ever fainted, had shortness of breath or chest pains?	☐	☐
11.	**WOMEN:** Are you pregnant? ☐Yes ☐No Using birth control? ☐Yes ☐No		
12.	Do you have or have ever had any of the following? Please √ appropriate boxes. ☐NONE		

☐ Anemia	☐ Glaucoma	☐ Mental Health Issues
☐ Angina	☐ Head/Neck injuries	☐ Oral Herpes
☐ Artificial Heart valve	☐ Heart disease/attack	☐ Organ transplant/implant
☐ Arthritis/rheumatism	☐ Heart murmur	☐ Psychiatric disorders
☐ Artificial joints (hips, knees)	☐ Heart pacemaker/surgery	☐ Radiation/Chemotherapy
☐ Asthma	☐ Heart rhythm disorder	☐ Rheumatic/Scarlet fever
☐ Blood disorders	☐ Hepatitis A/B/C	☐ Sinus trouble
☐ Bulima	☐ High/Low Blood pressure	☐ Stomach/intestinal problems
☐ Cancer	☐ H.I.V./A.I.D.S.	☐ Stroke
☐ Cortisone/Steroid Treatment	☐ Kidney disease	☐ Thyroid disease
☐ Diabetes	☐ Liver disease	☐ Tuberculosis
☐ Drug/alcohol dependence	☐ Leukemia	☐ Ulcers
☐ Epilepsy	☐ Lung disease	☐ Venereal disease/STD
		Other _____

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____

Signature ☐ Patient ☐ Parent / Guardian

_____ _____

Print Name Date

Dartmouth Dental Centre *Thank You*