# Elgin Dental Centre

## New Client Information

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 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**

1. hospitalization for illness or injury _____ ◯ ◯
2. an allergic reaction to
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulpha
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (nickel, gold, silver, _____)
   - ☐ latex
   - ☐ 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. artificial prosthesis (heart valve or joints) _____ ◯ ◯
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. emphysema, sarcoidosis _____ ◯ ◯
14. tuberculosis _____ ◯ ◯
15. asthma _____ ◯ ◯
16. breathing or sleep problems (i.e. 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 disorders (i.e. gastric reflux) _____ ◯ ◯
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __ ◯ ◯
27. arthritis _____ ◯ ◯
28. glaucoma _____ ◯ ◯
30. head or neck injuries _____ ◯ ◯
31. epilepsy, convulsions (seizures) _____ ◯ ◯
32. neurologic problems (attention deficit disorder) _____ ◯ ◯
33. viral infections and cold sores _____ ◯ ◯
34. any lumps or swelling in the mouth _____ ◯ ◯
35. hives, skin rash, hay fever _____ ◯ ◯
36. venereal disease _____ ◯ ◯
37. hepatitis (type ___) _____ ◯ ◯
38. HIV / AIDS _____ ◯ ◯
39. tumor, abnormal growth _____ ◯ ◯
40. radiation therapy _____ ◯ ◯
41. chemotherapy _____ ◯ ◯
42. psychiatric treatment _____ ◯ ◯
43. antidepressant medication _____ ◯ ◯
44. alcohol / drug dependency _____ ◯ ◯

**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) ◯ ◯
48. taking dietary supplements _____ ◯ ◯
49. often exhausted or fatigued _____ ◯ ◯
50. subject to frequent headaches _____ ◯ ◯
51. a smoker or smoked previously _____ ◯ ◯
52. FEMALE - taking birth control pills _____ ◯ ◯
53. FEMALE - pregnant _____ ◯ ◯
54. MALE - prostate disorders _____ ◯ ◯

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) [____] _____ ◯ ◯
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? _____ ◯ ◯
6. Have you had any teeth removed? _____ ◯ ◯

## SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ◯ ◯
8. Have you ever whitened (bleached) your teeth? _____ ◯ ◯
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ◯ ◯
10. Have you been disappointed with the appearance of previous dental work? _____ ◯ ◯

## BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ◯ ◯
12. Do you / would you have any problems chewing gum? _____ ◯ ◯
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ◯ ◯
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ◯ ◯
15. Are your teeth crowding or developing spaces? _____ ◯ ◯
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ◯ ◯
17. Do you clench your teeth in the daytime or make them sore? _____ ◯ ◯
18. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ◯ ◯
19. Do you wear or have you ever worn a bite appliance? _____ ◯ ◯

## TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? _____ ◯ ◯
21. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ◯ ◯
22. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ◯ ◯
23. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ◯ ◯
24. Do you have grooves or notches on your teeth near the gum line? _____ ◯ ◯
25. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ◯ ◯
26. Do you get food caught between any teeth? _____ ◯ ◯

## GUM AND BONE

27. Do your gums bleed when brushing or flossing? _____ ◯ ◯
28. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ◯ ◯
29. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ◯ ◯
30. Is there anyone with a history of periodontal disease in your family? _____ ◯ ◯
31. Have you ever experienced gum recession? _____ ◯ ◯
32. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ◯ ◯
33. Have you experienced a burning sensation in your mouth? _____ ◯ ◯

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____