



DowntownWhitby — DENTISTRY —

The information in this questionnaire is CONFIDENTIAL and enables our office to provide the highest level of care and service possible. Please complete all forms as completely as possible. Thank you.

PATIENT CONTACT INFORMATION

Mr Mrs Ms Miss Dr

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ (DD/MM/YY) Male Female

Address: _____ Apt/Unit #: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Marital Status: Single Married/Common Law Other

Employer: _____ Position: _____

May we contact you at your workplace? Yes No Work Number: _____

May we contact you on your cell phone? Yes No Cell Number: _____

May we contact you by email? Yes No Email address: _____

In case of an emergency please notify: _____ Phone number: _____

Best way to contact you? Home Work Cell Email Best time to contact you? Morning Afternoon Evening

INSURANCE INFORMATION

Primary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)

Insurance Policy Holder: Self Parent/Guardian Other _____

Policy Holder Phone Number (if different from above): _____ Employer: _____

Insurance Company Name: _____ Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Secondary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)

Insurance Policy Holder: Self Parent/Guardian Other _____

Policy Holder Phone Number (if different from above): _____ Employer: _____

Insurance Company Name: _____ Group Policy/Plan Number: _____ I.D./Certificate Number: _____

REFERRAL INFORMATION

How did you hear about us? (Check all that apply)

Internet — Website/search engine source: _____

Flyer — flyer description: _____

Newspaper — newspaper name(s): _____

Word of Mouth — name of person: _____

Walked By Other — please specify: _____

DENTAL HISTORY

Please share the following dates:

Date of last dental visit: _____ Date of last dental cleaning: _____

Date of last dental x-rays: _____ Your last oral cancer screening: _____

Do you smoke or use chewing tobacco? Yes No

If yes, how often? _____ For how long? _____

Please check any of the following problems that may apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Sensitivity (hot, cold and/or sweet) | <input type="checkbox"/> Headaches, earaches or neck pain |
| <input type="checkbox"/> Tooth pain or discomfort while chewing | <input type="checkbox"/> Grinding or clenching teeth |
| <input type="checkbox"/> Bleeding teeth or fillings | <input type="checkbox"/> Jaw joint pain (clicking/cracking) |
| <input type="checkbox"/> Broken teeth or fillings | <input type="checkbox"/> Bad breath or bad taste in your mouth |
| <input type="checkbox"/> Loose, tipped or shifting teeth | <input type="checkbox"/> Sore spots/growths |

Do you have or have you ever had any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Braces |
| <input type="checkbox"/> Partial dentures | <input type="checkbox"/> Periodontal (gum) treatments |
| <input type="checkbox"/> Difficult extractions | |

If you could change your smile, you would...

- | | |
|---|--|
| <input type="checkbox"/> Make your teeth brighter | <input type="checkbox"/> Repair chipped teeth |
| <input type="checkbox"/> Make your teeth straighter | <input type="checkbox"/> Replace missing teeth |
| <input type="checkbox"/> Close spaces | <input type="checkbox"/> Replace old crowns that don't match |
| <input type="checkbox"/> Replace black metal fillings with natural, tooth coloured fillings | <input type="checkbox"/> Have a smile makeover |

What is the name of your previous dentist?

Why did you leave your previous dentist?

What if anything, in the past has kept you from having dental treatment?

What is the most important thing to you about your future smile and dental health?

MEDICAL HISTORY

Please check any of the following that apply to you:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Allergies, seasonal | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HPV | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart lesions, congenital | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Phen fen (1 month+) | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Pregnant currently | <input type="checkbox"/> Venereal diseases |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Radiation (head/neck) | <input type="checkbox"/> Other _____ |

Do you have any of the following allergies?

- | | | | |
|-------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulpha | <input type="checkbox"/> Nitrous oxide |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local anaesthetic | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Percocet | <input type="checkbox"/> Other _____ | |

Have you ever had a joint replacement? Yes No If yes, when? _____

Have your physician ever told you to take antibiotics prior to dental procedures? Yes No

If so, why? _____

Have you ever experienced complications following a medical or dental procedure? Yes No

If yes, please describe: _____

Is there anything else you think we should know regarding your medical history? Yes No

If yes, please describe: _____

Are you currently under a physician's care? Yes No If yes, what for? _____

Are you taking any medications? Yes No If yes, please specify: _____

Family Physician's Name: _____ Phone Number: _____

PRIVACY INFORMATION

I certify that I have read, understood and accurately completed the personal, medical, and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information

I agree that Downtown Whitby Dentistry has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Date: _____ Signature: _____