Medical and Dental Questionnaire

Personal Information:

Mr/Mrs/Miss/Ms____**Date of birth d ____/m_____/y_____**

Address: _________________________ ______________City: ______________________ Postal Code: _________

Home Phone: _________________ Cell Phone: __________________ Business Phone: _______________________

Health Card Number: ___________________________ Email Address:______________________________________

Referred by: ____________________________________ (example: Friend/Family (provide name),Facebook, Phonebook, Newpaper Add, ect)

Previous Dentist: _____________________________ Personal Physician: ___________________________________

In case of emergency notify: Name: _______________________ Phone Number: ___________________________
Relationship: ___________________________

Insurance:
Dental Insurance Company? ___________________________ Subscriber ID: _________________________
Policy identification no.______________________

The following information is required to enable us to provide you with the best possible dental care. All information is strictly confidential. Please complete the entire form.
1-Do you or have you had any of the following conditions? Please circle if so.

Heart Attack – If so when?	Stroke/TIA -If so when? Pacemaker	Angina/Chest Pain/Shortness of Breath	Atrial Fibrillation/Heart Arrhythmia/Irregular Heart Beat	Congenital Heart Disease	Heart Valve Replacement/Repair-If so when?
Low Blood Pressure	High Blood Pressure	Faint/Dizzy Spells/Light-headedness/Vertigo	COPD/Emphysema	Asthma	Sleep Apnea
Cancer, If so when?	Diabetes, If so what type? Is it controlled?	Malignant Hyperthermia	Rheumatic/Scarlet Fever Liver Disease	Drug or Alcohol Dependence	Steroid Therapy Kidney Disease
Heartburn/Gastric Reflux	Stomach Ulcers	HIV or Aids	Hepatitis, if so what type?	Autoimmune Disorder, type?	Thyroid Disease, if so is it Hypo or Huper?

Chronic Neck and or Back Pain	Osteoporosis	Seizures or Epilepsy, if so what was the last date of your seizure?	Blood Disorder (example, Anemia, Sickle Cell, Factor 5 ect…)	ADD/ADHD Alzheimer's/Dementia	Developmentally Delayed Autism Spectrum Disorder
Depression Anxiety	Psychiatric Disorder Non-Verbal	Hearing Difficulty/Impairment	Glaucoma Glasses/Contacts	Requires wheelchair access, if so can you transfer alone?	

2- Are you being treated for any medical conditions at present, or within the past 5 years?

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3- Do you have a prosthetic or artificial joint? If so, please list the date of placement and the location.

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4- Do you smoke or chew tobacco products? If you have quit, when? ____________________________

5- Do you vaporise or use electronic cigarettes? Y or N

6- Are you pregnant or breastfeeding? If you are pregnant, when are you expecting? __________________

7- Do you have any allergies? (sensitivities or adverse reactions to medications) If so, please list allergies to medications and other allergies (ex: food, environmental)___________________________________

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8- Do you have an allergy to latex? Y or N

9- Are you currently taking any medications? (prescriptions, patches, inhalers, vitamins, supplements, holistic or non-prescription drugs, marijuana (medical or recreations?)) If so, please list your medications.

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10- What is your pharmacy's name?____

11- Do you currently take any prescription blood thinners? (example: Coumadin, Warfarin, Pradaxa, Dabigatran, Xarelto, Plavis, Eliquis, ect.) If so, please list them. ____

12- Have you ever been treated for osteoprosis? Please list the following medication you are currently taking or have taken. (example: Fosamax, Didrocal, Actonel, Aclasta, Proila, Fosavance, ect) If so, how long have you been taking them? ____

13- Have you had any surgeries, major illnesses or hospitalizations? If so, please list. __________________

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14- Are there any medical conditions or diseases not listed above that you currently have? If so, please list them.

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15- What is the date of your list visit to your physician? _______________________________________

16- Does dentistry/dental treatment cause you anxiety? If so, please explain? _______________________

17- When was your last dental cleaning? ___________________

18- How many times a day do you floss? ___________ 19- How many times a day to you brush? ________

19- Do you use any aids for dental hygiene. (example: Air flosser, Electronic Toothbrush, Proxabrush, ect)

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20- Our office currently offers a referral program. Anyone who refers a friend, family member ect to our practice will receive a thank you card and a gift certificate. How did you hear about us? ___________________________

Dental Information

When did you last visit the dentist? ____

For what reason? ____

Have you ever had: Periodontal (gum) treatment? Y or N

Orthodontic (braces) treatment? Y or N

Do you have any specific dental concerns? ____

To the best of my knowledge, the above information is correct. I authorize release to my insurance plan/administrator, the information contained in claims submitted electronically.

Patient/Parent/Guardian Signature: ________________________________Date: ________________________