



PATIENT DENTAL & MEDICAL FORM

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FAIRFIELD VILLAGE DENTAL CENTRE

Mr <input type="radio"/> Mrs <input type="radio"/> Ms <input type="radio"/> First name:	Last name:	Initial:
Date of birth (DOB): DD / MM / YYYY	Age:	Sex: M, F, Other
Address:		Postal code:
Email address:	Phone:	Cell:
Occupation:	Employer:	
Emergency contact:	Phone:	
Primary physician/doctor:	Phone:	
Primary dental insurance:	Group/Policy#:	ID#:
Secondary dental insurance:	Group/Policy#:	ID#:
Secondary policy holder's first name:	Last name:	DOB: DD / MM / YYYY
How did you hear about our office?		Referred by:

Personal Dental History

- 1 Are you **fearful of dental treatment?** Y N
- 2 Have you ever had an **unfavourable dental experience?**
- 3 Have you ever had **complications following dental treatment?**
- 4 Have you experienced **reactions to dental anesthetics** or do you have **trouble getting numb?**
- 5 Have you had **teeth removed** in the past?

Smile Characteristics

- 6 Is there anything about the **appearance of your teeth that you would like changed?** Y N
- 7 Have you ever **bleached your teeth?**
- 8 Are you **self conscious about your teeth or smile?**
- 9 Have you been **disappointed with the appearance** of past dental work?

Bite and Jaw Joint

- 10 Do you or would you have **difficulty chewing gum?** Y N
- 11 Do you or would you experience **difficulties chewing hard foods** (bagels)?
- 12 Have your teeth become **shorter, thinner or worn** over the last 5 years?
- 13 Have your teeth become **crowded** or developed **spaces** between them in the last 5 years?
- 14 Do you have **more than one bite** or do you **clench (squeeze)** to make your teeth fit together?
- 15 Do you have **trouble sleeping** or wake up with an awareness of your teeth?
- 16 Do you or have you experienced **problems with your jaw joint** (pain, clicking, popping, sounds)?
- 17 Has your **jaw ever locked** open or shut?
- 18 Have you ever worn a **bite appliance or night guard?**
- 19 Do you experience frequent **tension headaches or sore teeth?**

Tooth Structure

- 20 Have you had a **cavity** within the last two years? Y N
- 21 Do you experience a **dry mouth?**
- 22 Are your **teeth sensitive** to hot, cold or sweets?
- 23 Have you ever had a **cracked tooth and or filling, toothache or broken tooth?**
- 24 **Do you avoid brushing or eating** in any particular part of the mouth?

Gum and Bone

- 25 Have you ever been diagnosed with or treated for **periodontal (gum) disease?** Y N
- 26 Have you experienced **gum recession?**
- 27 Do your **gums bleed** when you floss or brush?
- 28 Is there a history of anyone in your immediate family with **early tooth loss or periodontal disease?**
- 29 Are your **teeth becoming loose?**
- 30 Have you ever noticed or experienced an **unpleasant odour or taste** in your mouth?

MEDICAL HISTORY

General Health

1. Are you currently under the care of a medical doctor? Y N

Condition(s) being treated: _____

Doctor's name (if different from your primary physician): _____

2. When was your last medical check-up?

Date: DD / MM / YYYY

3. Have you experienced excessive weight gain or loss recently? Y N

4. Women: Are you currently pregnant or breast feeding? Y N

5. Have you been hospitalized previously? Y N

Reason(s): _____

6. Have you been, or are you currently being, treated for a mental illness? Y N

Conditions

7. Have you ever been diagnosed or treated for any of the following?

Heart problems

Heart failure Y N

Heart disease Y N

Heart murmur Y N

Angina pectoralis, chest pain Y N

Heart attack Y N

High blood pressure Y N

Low blood pressure Y N

Rheumatic fever Y N

Mitral valve prolapse Y N

Arrhythmia Y N

Stroke Y N

Congenital heart defect Y N

Breathing and Lungs

Hay fever Y N

Sinus problems Y N

Tuberculosis Y N

Asthma Y N

Emphysema Y N

Chronic obstructive pulmonary disease Y N

Digestive Problems

Chrones disease Y N

Ulcerative colitis Y N

Celiac disease Y N

Kidney disease Y N

Liver disease Y N

Stomach, duodenal ulcers Y N

Gastroesophageal reflux disease (GERD) Y N

Blood Disorders

Hemophilia Y N

Anemia Y N

Leukemia Y N

Prolonged bleeding Y N

Metabolic Disorders

High cholesterol Y N

Diabetes Y N

Hyperthyroidism Y N

Osteoporosis Y N

Hormone deficiency Y N

Addison's disease Y N

Cushing's disease Y N

Viral Ailments

Hepatitis A, B, C Y N

AIDS/HIV Y N

Cold sores Y N

Other Conditions

Epilepsy Y N

Malignant hyperthermia/ malignant hyperpyrexia Y N

Arthritis Y N

Glaucoma Y N

Frequent headaches Y N

Fibromyalgia Y N

Bulimia/anorexia Y N

Cancer Y N

Substance abuse Y N

Smoking Y N

Hearing impairment Y N

Psychiatric ailment(s) Y N

Reactions or Allergies

8. Have you ever experienced a reaction to, or are you aware of an existing allergy to, any of the following?

Metals (gold, silver, nickel) Y N

Local or general anesthetics Y N

Latex Y N

Tetracycline Y N

Fluoride Y N

Penicillin Y N

Codeine Y N

Sulfa based medications Y N

Aspirin, acetaminophen, ibuprophen Y N

Known allergy to other medication(s) Y N

List: _____

Medications

9. Are you currently taking any of the following drugs? Y N

High blood pressure medication Y N

Antidepressant medications Y N

Steroid or corticosteroids (incl. prednisone) Y N

Nitroglycerine Y N

Dilantin or anticonvulsants Y N

Blood thinners (plavix, heparin, coumadin, warfarin) Y N

Birth control pill Y N

Insulin, metformin, tolbutamide Y N

Tranquilizers Y N

Antibiotics Y N

Bisphosphonates (Fosamax, Didrocal, Actonel, Y N

Aclasta or Fosavance) Y N

Do you take other medication(s)? Y N

List medication(s), dosage and pharmacy: _____

Medical Procedures

10. Have you undergone, or are you currently undergoing, any of the following medical procedures? Y N

An artificial joint replacement Y N

An artificial heart valve placement Y N

An organ transplant Y N

Chemotherapy for cancer Y N

Radiation therapy for cancer Y N

Blood transfusion Y N

Dialysis Y N

Pacemaker or defibrillator Y N

Have you had complications due to treatment? Y N

Describe: _____

To the best of my knowledge, all of the information provided above is true and correct. In the event of a change in my health, medications, medical status or an abnormal laboratory test, I will inform the dentist at my next dental visit.

Patient, parent or legal guardian: _____ Signature: _____ Date: DD / MM / YYYY
 Witnessed or reviewed by: _____ Signature: _____ Date: DD / MM / YYYY