FAIRFIELD VILLAGE DENTAL CENTRE

PATIENT DENTAL & MEDICAL FORM

Mr ◯ Mrs ◯ Ms ◯ **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	Y	N
1 Are you **fearful of dental treatment?**	◯	☐
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	Y	N
6 Is there anything about the **appearance of your teeth that you would like changed**?	◯	☐
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	Y	N
10 Do you or would you have **difficulty chewing gum**?	◯	☐
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	Y	N
20 Have you had a **cavity** within the last two years?	◯	☐
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	Y	N
25 Have you ever been diagnosed with or treated for **periodontal (gum) disease**?	◯	☐
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 Y N

1. Are you currently under the care of a medical doctor? ○ ☐

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? ○ ☐

4. Women: Are you currently pregnant or breast feeding? ○ ☐

5. Have you been hospitalized previously? ○ ☐

Reason(s):

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

Conditions

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

Heart problems	Y	N
Heart failure	○	☐
Heart disease	○	☐
Heart murmur	○	☐
Angina pectoralis, chest pain	○	☐
Heart attack	○	☐
High blood pressure	○	☐
Low blood pressure	○	☐
Rheumatic fever	○	☐
Mitral valve prolapse	○	☐
Arrhythmia	○	☐
Stroke	○	☐
Congenital heart defect	○	☐

Breathing and Lungs	Y	N
Hay fever	○	☐
Sinus problems	○	☐
Tuberculosis	○	☐
Asthma	○	☐
Emphysema	○	☐
Chronic obstructive pulmonary disease	○	☐

Digestive Problems	Y	N
Chrones disease	○	☐
Ulcerative colitis	○	☐
Celiac disease	○	☐
Kidney disease	○	☐
Liver disease	○	☐
Stomach, duodenal ulcers	○	☐
Gastroesophageal reflux disease (GERD)	○	☐

Blood Disorders	Y	N
Hemophilia	○	☐
Anemia	○	☐
Leukemia	○	☐
Prolonged bleeding	○	☐

Metabolic Disorders	Y	N
High cholesterol	○	☐
Diabetes	○	☐
Hyperthyroidism	○	☐
Osteoporosis	○	☐
Hormone deficiency	○	☐
Addison's disease	○	☐
Cushing's disease	○	☐

Viral Ailments	Y	N
Hepatitis A, B, C	○	☐
AIDS/HIV	○	☐
Cold sores	○	☐

Other Conditions	Y	N
Epilepsy	○	☐
Malignant hyperthermia/ malignant hyperpyrexia	○	☐
Arthritis	○	☐
Glaucoma	○	☐
Frequent headaches	○	☐
Fibromyalgia	○	☐
Bulimia/anorexia	○	☐
Cancer	○	☐
Substance abuse	○	☐
Smoking	○	☐
Hearing impairment	○	☐
Psychiatric ailment(s)	○	☐

Reactions or Allergies Y N

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)	○	☐
Local or general anesthetics	○	☐
Latex	○	☐
Tetracycline	○	☐
Fluoride	○	☐
Penicillin	○	☐
Codeine	○	☐
Sulfa based medications	○	☐
Aspirin, acetaminophen, ibuprophen	○	☐
Known allergy to other medication(s):	○	☐

List:

Medications Y N

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

High blood pressure medication	○	☐
Antidepressant medications	○	☐
Steroid or corticosteroids (incl. prednisone)	○	☐
Nitroglycerine	○	☐
Dilantin or anticonvusants	○	☐
Blood thinners (plavix, heparin, coumadin, warfarin)	○	☐
Birth control pill	○	☐
Insulin, metformin, tolbutamide	○	☐
Tranquilizers	○	☐
Antibiotics	○	☐
Bisphosphonates (Fosamax, Didrocal, Actonel, Aclasta or Fosavance)	○	☐
Do you take other medication(s)?	○	☐

List medication(s), dosage and pharmacy:

Medical Procedures Y N

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

An artificial joint replacement	○	☐
An artificial heart valve placement	○	☐
An organ transplant	○	☐
Chemotherapy for cancer	○	☐
Radiation therapy for cancer	○	☐
Blood transfusion	○	☐
Dialysis	○	☐
Pacemaker or defibrillator	○	☐
Have you had complications due to treatment?	○	☐

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