DATE

WELCOME TO ORLEANS GARDENS DENTAL CENTRE

PID#_____
DR _____

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. Please answer the questions as accurately as you can. All information is strictly confidential and will remain with this office. We understand the importance of protecting your personal information. Orleans Gardens Dental Centre has a privacy code outlining the collection, use and disclosure of your personal information. **PLEASE PRINT.**

REGISTRATION INFORMATION

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Email: _____

The patient is an: Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian: _____

Name: (last) (first) (initial) (prefers to be called)

Address: (street) (Apt.#) (city) (postal code)

Birth Date: M. _____ D. _____ Y. _____
Home Phone: ( ) _____ - _____
Bus. Phone: ( ) _____ - _____
Cell Phone: ( ) _____ - _____

Age: _____ Sex: _____ May we call you at work? Yes ☐ No ☐ Employer: _____

Family Physician: _____ Phone: ( ) _____

Are you under the care of a Medical Specialist? Yes ☐ No ☐ _____ Phone: ( ) _____

In case of emergency, please contact: _____ Relationship: _____ Phone: ( ) _____

INSURANCE INFORMATION

Do you have insurance? Yes ☐ No ☐ Insurance Co. _____

Name of Policy Holder: _____ /D__ M__ Y__ Relationship to Policy Holder _____ Policy No. _____ Cert. No. _____

Do you have secondary insurance? Yes ☐ No ☐ Insurance Co. _____

Name of Policy Holder: _____ /D__ M__ Y__ Relationship to Policy Holder _____ Policy No. _____ Cert. No. _____

☐ **I understand that I am responsible for full treatment fees on my account, and I authorize Orleans Gardens Dental Centre to submit claims and/or predeterminations electronically and/or by mail on my behalf. I understand Orleans Gardens Dental Centre has a privacy code which I may ask to see at any time.**

Signature _____ **Date** _____

DENTAL HISTORY

(Please ✓ **Yes or No** to each question. If unsure, please consult with the dentist.)

YES NO

☐ ☐ 1. Is there a dental problem you would like treated immediately? If yes, please specify _____
Previous dentist: _____ Date of last dental visit: _____ cleaning: _____ x-rays: _____
Frequency of brushing _____ Frequency of flossing _____

☐ ☐ 2. Have you seen a dental specialist for gum treatment / orthodontics / oral surgery? (Please circle) Name of Specialist: _____

☐ ☐ 3. Have you ever had any injury or surgery to your face or jaws? _____

4. Are you experiencing any of the following: (please ✓)

☐ - Pain or swelling of your gums
☐ - Growths or sore spots
☐ - Food catching between your teeth
☐ - Sensitivity to heat, cold, sweets or pressure (please circle)
☐ - Pain / popping / clicking in your jaw joints / side face
☐ - Difficulty opening or closing
☐ - Pain or difficulty while chewing
☐ - Clenching or grinding
☐ - Headaches or earaches

☐ ☐ 5. Do you have any emotional concerns about having dental treatment? If yes, please explain _____

☐ ☐ 6. Are you happy with the appearance of your teeth? If not, what would you like to see changed? _____

☐ ☐ 7. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____

MEDICAL HISTORY

(Please ✓ **Yes or No** to each question. If unsure of a question, please consult with the dentist.)

YES NO

☐ ☐ 1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____

☐ ☐ 2. Have you been hospitalized in the past two years?

☐ ☐ 3. Has there been any change in your general health in the past year? If yes, please specify _____

☐ ☐ 4. When was your last visit to a Physician? _____ Last complete physical examination _____

☐ ☐ 5. Do you have an Intolerance or Allergies?, If yes please specify _____
_____

☐ ☐ 6. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath? If yes please explain _____
_____

MEDICAL HISTORY (cont.)

(Please ✓ **Yes or No** to each question. If unsure of a question, please consult with the dentist.)

YES NO

☐ ☐ 7. Have you recently, or are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? If yes, please specify below.

Name of Medication	Dosage	Frequency

☐ ☐ 8. Have you ever been advised against taking any specific type of medication? If yes please specify _____

☐ ☐ 9. Are you taking any vitamins or herbal supplements? _____

☐ ☐ 10. Do you bleed EXCESSIVELY from a cut or injury or bruise easily?_____

☐ ☐ 11. Do you experience shortness of breath or chest pain when walking or climbing stairs? _____

☐ ☐ 12. Have you been advised to take antibiotics prior to dentist treatment?_____

☐ ☐ 13. Do you smoke or use any other forms of tobacco / nicotine patch / cannabis?_____

☐ ☐ 14. Are you alcohol and/or drug dependent? If yes, have you received treatment? _____

15. INDICATE ✓ WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

- ☐ A.I.D.S.
- ☐ Anemia
- ☐ Angina pectoris
- ☐ Arthritis/rheumatism/osteoporosis
- ☐ Artificial heart valve
- ☐ Artificial joints (hip, knee) Date_____
- ☐ Asthma
- ☐ Blood disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ Circulation problems
- ☐ Congenital heart lesions
- ☐ Cortisone/steroids
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ Glandular disorders
- ☐ Glaucoma
- ☐ Head/neck injuries
- ☐ Heart disease or attack
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Heart rhythm disorder
- ☐ Heart surgery
- ☐ Hepatitis A, B, C _____
- ☐ Herpes
- ☐ High/Low blood pressure
- ☐ Hodgkins disease
- ☐ Hyper (Hypo) Glycemia
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Lupus
- ☐ Malignant Hyperthermia
- ☐ Mental/nervous disorder
- ☐ Mitral valve prolapse
- ☐ Organ transplant/medical implant
- ☐ Psychiatric treatment
- ☐ Radiation treatment/chemotherapy
- ☐ Rheumatic/Scarlet fever
- ☐ Sickle cell disease
- ☐ Sinus trouble
- ☐ Stomach/intestinal problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other _____
- ☐ Other _____

☐ ☐ 16. Have you, or do you currently have any disease, condition or problem not listed above? _____

☐ ☐ 17. Is there anything else about you that we should be made aware of?_____

☐ ☐ 18. Has the **CHILD PATIENT** recently had any of the following: (indicate approximate date)

☐ Measles _____ ☐ Strep throat _____ ☐ Mumps _____ ☐ Tonsillitis _____ ☐ Chicken Pox _____

☐ ☐ 19. **WOMEN ONLY:** Are you pregnant or suspect you may be? If yes, what is the expected delivery date? _____

☐ ☐ 20. Are you taking any birth control pills? If yes, please specify _____

GENERAL RELEASE

IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Patient ☐ Parent ☐ Guardian ☐ X _____ Print name of guardian _____

Reviewed by Treating Dentist: _____ Date: _____