Kitchener East Family Dental
WE MAKE YOUR FAMILY SMILE

PATIENT INFORMATION

Mr. ○ Mrs. ○ Miss. ○ Ms. ○ Dr. ○ ADULT ○ CHILD ○

Name _____ Prefer to be Called: _____

Address: _____

Home Phone: _____ Work Phone: _____ Date of Birth: _____

Email: _____ Cell: _____ Male ○ Female ○

Marital Status:

Employer/School: _____ Occupation: _____

Whom may we thank for referring you to this office? _____

Are you likely to be available on short notice for future appointments or appointment changes? Yes ○ No ○

What is your primary choice for us to contact you? Email Home ○ Work ○ Cell ○

Family Physician: _____ Phone: _____

In Case of Emergency Notify: _____ Relation: Phone: _____

Person responsible for this account: Self ○ Spouse ○ Parent ○ Legal Guardian ○ Other: ○

Name: _____ Relation: _____

Address: _____

Home Phone _____ Work Phone _____

MEDICAL HISTORY — ALL INFORMATION IS CONFIDENTIAL

The following information is required by the dentist to assist in proper diagnosis and treatment.

	Yes	No
1) Have you ever had a serious illness requiring hospitalization or extensive medical care? Please specify:	☐	☐
2) Are you presently under the care of a physician? If so, please explain	☐	☐
3) Have you had a medical examination in the last year?	☐	☐
4) Do you use any prescription or non-prescription drugs regularly? Please specify:	☐	☐
5) Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? Please specify:	☐	☐
6) Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? Please specify:	☐	☐
7) have you been hospitalized in the last 5 years? Please specify:	☐	☐
8) Have you ever experienced any unusual reaction to any of the following? local anesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? If so please explain:	☐	☐
9) Have you been warned against taking any drug or medication?	☐	☐
10) Do you bruise easily or bleed abnormally?	☐	☐
11) Have you ever had any organ implants or medical implants?	☐	☐
12) Have you ever fainted?	☐	☐
13) Do you ankles swell?	☐	☐

14) Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ☐ ☐

15) Do you have frequent headaches? ☐ ☐

16) Do you have A.I.D.S. or have ever tested positive for H.I.V.? ☐ ☐

17) Do you have any of the following? Please check all that apply

☐ Heart Murmur or Mitral Valve Prolapse	☐ Malignant Hyperthermia	☐ Liver Disease	☐ Herpes
☐ Stomach/Intestinal Problems/Ulcers	☐ Drug/Alcohol Dependency	☐ Heart Attack	☐ Sinus Trouble
☐ Joint Replacement (hip, knee, etc.)	☐ Venereal Disease	☐ Cold Sores	☐ Stroke
☐ Mental or Nervous Disorder	☐ Lung Disease (i.e. Asthma)	☐ Jaundice	☐ Kidney Problems
☐ High/low Blood Pressure	☐ Thyroid Disease	☐ Diabetes	☐ Emphysema
☐ Hyper (hypo) Glycemia	☐ Arthritis or Rheumatism	☐ Tuberculosis	☐ Glaucoma
☐ Epilepsy or Seizures	☐ Scarlet or Rheumatic Fever	☐ Hepatitis A, B, C	
☐ Cortisone/Steroid Therapy	☐ Cancer/Chemotherapy	☐ Other:	

18) Have you had any injury, surgery, or x-ray therapy to your face or jaws? ☐ ☐

19) Do you have any disease, condition, or problem that you think your doctor should know about? ☐ ☐

20) WOMEN ONLY - Are you pregnant or suspect you might be? If so, what month are you in?

Are you taking birth control pills? ☐ ☐

Are you nursing? ☐ ☐

1) Reason for today's visit: Exam ☐ Cleaning ☐ Emergency ☐ Other

Are you presently having dental pain? ☐ ☐

Is there a dental problem you would like to take care of as soon as possible? ☐ ☐

Please specify:

2) How often do you brush your teeth? Floss?

3) Do your gums bleed easily? ☐ ☐

4) Are your teeth sensitive to: Hot ☐ Cold ☐ Biting ☐ Sweets ☐

5) Do you feel you have bad breath at times? ☐ ☐

6) Have you ever had jaw joint surgery? ☐ ☐

7) Do you have pain in your jaw joints or suffer from migraine headaches? ☐ ☐

8) Does any part of your mouth hurt when clenched? ☐ ☐

9) Does your jaw crack or pop when opened widely? ☐ ☐

10) Have you had: Braces ☐ Oral Surgery ☐ Gum Treatment ☐ Root Canal ☐

11) Do you grind or clench your teeth during the day or night? ☐ ☐

12) Do you smoke? Number per day: ☐ ☐

13) Are you interested in straightening your teeth? ☐ ☐

14) Have you ever experienced any growths or sore spots in your mouth? Is so, where? ☐ ☐

15) Previous problems with dental treatment? ☐ ☐

Please specify:

16) Are you satisfied with the appearance of your teeth? ☐ ☐

Please specify:

17) Other Dental Concerns:

General Consent statement:

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, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatments to achieve the proper level of dental care. I authorize the dentist and staff to take photographs in connection with dental services. These photographs may be used for diagnostic records, research, education, patient counseling, public relations or other purposes. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive. In accordance with Bill C-28: By providing your email address and or cell phone number you consent to correspondence regarding products, services, appointments, newsletters or any other communication associated with Kitchener East Family Dental.. Upon my request, I have been provided with a copy of the Privacy Code and agree that personal information may be collected, used and disclosed as set out in the Code and is in accordance with the Personal Health Information Protection Act, 2004. I am aware that missing an appointment or failing to give two business days' notice for a cancellation may result in a cancellation fee. Consent to Electronic Submission of Insurance Claims: I authorize release, to my benefits plan administer and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of service described to Kitchener East Family Dental. This authorization shall continue until the undersigned revokes the same.

(SIGNATURE) **PATIENT ○ PARENT ○ GUARDIAN ○** **DATE** **REVIEWING DENTIST**