Adult Questionnaire

Patient's Name: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____

How do you prefer to be addressed? _____

Home Address: _____

City: _____ Province: _____ Postal Code:_____ Email: _____

Tel: H: _____ W: _____ ext::_____ Cell: _____

Birth Date:M:_____D:_____Y:_____ Age: _____ Birthplace: _____

How did you hear about our off ice? _____

Have you seen us in the following:☐ T.V. Commercial ☐ Newspaper Ad. ☐ Magnet ☐Fireworks Display ☐Magazine Ad.

☐ Internet Web Site ☐ Sponsorship ☐ Yellow Pages ☐Other _____

Insurance Information

Do you have dental insurance? ☐Yes ☐No Name of Insured:_____ Birth Date: M:___D:___ Y: ___

Employer: _____ Address: _____ How Long ____ yrs.

Insurance Company Name:_____Check-up frequency: ❑twice/year❑6 months❑9 months ❑ 12 months

Policy or Group Number:_____ I.D. or Certificate number: _____

Dental and Medical History

Main reason for visit today: _____

Date of last dental check-up: _____month/year Are you nervous about seeing a Dentist?: ☐Yes ☐No

Name of last dentist:_____Number of years as his/her patient: _____

Why have you changed dentists? _____

Have you had your wisdom teeth extracted? ☐ Yes ☐ No When?:_____ years ago Reason: _____

Are you interested in improving the appearance of your smile? ☐ Yes ☐ No Bleaching your teeth? ☐ Yes☐No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (please check if applicable)

☐ Teeth sensitive to: ☐Cold ☐Hot☐Sweets☐Pressure
☐ Periodontal (gum) treatment
☐ Bleeding gums - if yes, how long?_____
☐ Frequent blisters on lips or mouth
☐ Orthodontic treatment
☐ Loose teeth
☐ Bad breath
☐ Food impaction
☐ Unpleasant taste
☐ Swelling in mouth

Family physician:_____ Telephone: _____ Address:_____

Are you currently under medical treatment? _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (please check if applicable)

☐ Rheumatic Fever
☐ Heart Murmur
☐ Congenital Heart Lesions
☐ High Blood Pressure
☐ Prosthetic Surgery (Heart Valves, Hip Joint)
☐ HIV Positive/ Aids
☐ Heart Surgery
☐ Thyroid Disorder
☐ Heart Attack
☐ Stroke
☐ Pacemaker
☐ Anemia or Blood Problems
☐ Diabetes
☐ Tuberculosis
☐ Kidney Disease
☐ Asthma
☐ Cancer
☐ Communicable Diseases
☐ Osteoporosis
☐ Surgery of any kind
☐ Hepatitis
☐ Pregnancy
Due Date _____

☐ Allergies to Medication: (please check if applicable)

☐ Penicillin ☐ Sulpha ☐ ASA List Medications:_____
☐ Codeine ☐ Erythromycin ☐ Other:_____ Do you smoke ☐ Yes ☐ No

Is there any other information about your health that we should know? _____

Please list all the medications you are presently taking: _____

I hereby consent to all dental and oral surgery procedures performed in this office including the use of nitrous oxide, x-rays and /or relevant anaesthesia as indicated and I accept responsibility for all fees charged for treatment rendered whether covered by insurance or not. In addition, I understand that a fee will be charged for missed appointments by myself where at least **48 hours notice** is not provided. I also give consent to photos being taken and used for treatment planning and patient education. I consent to submission of my dental claims electronically to my insurance company. I also consent to your collection, of any and all personal information about me including personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relating to, your dental practice. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or part of any treatment or service you provide.

Patient's Signature: _____**Date** _____