L'EXPÉRIENCE DENTAIRE

PATIENT INFORMATION

Name: _____ ☐ M ☐ F Date of birth: _____
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Cellular Phone: _____
Work Phone: _____ Ext. _____ Email address: _____

Emergency contact name: _____ Phone: _____
How did you hear about our dental office? _____

Do you have a dental insurance? ☐ Yes ☐ No

MEDICAL HISTORY

For the following questions, please select whichever applies. The information that is requested is essential in providing you with the highest standard of dental care. Your answers are for our records only and will be kept confidential.

1. Are you in good health?
   ☐ Yes ☐ No Date of last physical exam? _____
2. Has there been any change in your general health within the past year?
   ☐ Yes ☐ No If yes, please explain: _____
3. Have you had any serious illness, operations or been hospitalized in the past 5 years?
   ☐ Yes ☐ No If yes, please explain: _____
4. Are you taking or have you recently taken any medicine(s), including non-prescription medicines?
   ☐ Yes ☐ No If yes, what medicine(s)? : _____
5. Do you use tobacco?
   ☐ Yes ☐ No If yes, what type? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing tobacco
6. Are you allergic to or have you had a reaction to: ☐ Yes ☐ No If yes, please indicate:

☐ Local Anesthetic	☐ Penicillin	☐ Codeine	☐ Food
☐ Sulfa drugs	☐ Animals	☐ Aspirin	☐ Iodine
☐ Hay fever	☐ Barbiturates/Sedatives	☐ Latex	☐ Other _____

7. Have you had an orthopedic joint (hip, knee, elbow, etc.) replacement?
   ☐ Yes ☐ No If yes, date of surgery: _____
8. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
   ☐ Yes ☐ No If yes, what antibiotic and dose: _____
   Name of physician or dentist: _____ Phone: _____

Please indicate if you have or have had any of the following diseases or problems

Anemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Abnormal bleeding	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
G.E. reflux	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No
Rheumatoid arthritis	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Neurological disorders	☐ Yes ☐ No	Sleep disorder	☐ Yes ☐ No
Fainting spells or seizures	☐ Yes ☐ No	Severe headaches	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Severe or rapid weight loss	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Oui ☐ Non	☐ Yes ☐ No
Chemotherapy/Radiation	☐ Yes ☐ No	AIDS or HIV infection	☐ Yes ☐ No

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Cardiovascular disease ☐ Yes ☐ No

If yes, please specify:
- ☐ Angina
- ☐ Hypertension
- ☐ Hypotension
- ☐ Arteriosclerosis
- ☐ Artificial heart valves
- ☐ Damaged heart valves
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Rheumatic heart disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker

Respiratory problems ☐ Yes ☐ No

If yes, please specify:
- ☐ Emphysema ☐ Tuberculosis
- ☐ Bronchitis ☐ Asthma

Diabetes ☐ Yes ☐ No

If yes, please specify:
- ☐ Type 1 (insulin dependant)
- ☐ Type 2

Hepatitis ☐ Yes ☐ No

If yes, please specify:
- ☐ A ☐ B ☐ C

Do you have any disease, condition or problem not listed above that we should be aware of?
☐ Yes ☐ No If yes, please specify: _____

For women only

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No
If yes, **WARNING**: Antibiotics may alter the effectiveness of the birth control pill.

For children only

Has the child recently had any of the following?

Measles	☐ Yes ☐ No	Strep throat	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Chicken pox	☐ Yes ☐ No	Indicate approximate date: _____	

DENTAL HISTORY

1. Reason for today's visit? _____
2. Date of last dental visit? _____ Date of last dental X-rays? _____
3. Date of last dental cleaning? _____ Have you ever had a local anesthetic? ☐ Yes ☐ No
4. Have you ever had an adverse reaction to a local anesthetic? ☐ Yes ☐ No
   If yes, please explain: _____
5. Have you ever had any serious trouble associated with a previous dental treatment? ☐ Yes ☐ No
   If yes, please explain: _____

Please indicate all that apply

- ☐ Bad breath
- ☐ Clicking or popping jaw
- ☐ Sensitivity to cold and/or hot
- ☐ Sores or growths in the mouth
- ☐ Bleeding gums
- ☐ Grinding or clenching of teeth
- ☐ Sensitivity to sweets
- ☐ Sensitivity when chewing
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing while awake or asleep

Do you find your teeth too dark or yellow? ☐ Yes ☐ No
Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No
If yes, what would you like to see changed? _____

GENERAL RELEASE AND CONSENT TO TREATMENT

I, the undersigned, guarantee that I have completed this questionnaire truthfully and to the best of my knowledge and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental clinic**. I authorize the dentist to perform all diagnostic procedures as required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care professional may be required.

I understand that the responsibility for payment of dental services provided in this office for myself or my dependants is mine. <u>THE PAYMENT IS DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED, UNLESS AN EXTENDED PAYMENT PLAN IS ARRANGED WITH THE DENTAL CLINIC.</u>

Signature: _____ Signature of treating dentist: _____
☐ patient ☐ parent ☐ guardian

Date: _____