Date _____

WELCOME TO OUR OFFICE

I.D. # _____

MEDICAL ALERT _____

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. If you have any questions or doubts, please ask the treating dentist or our receptionist, who is available to assist you with the completion of this form. All information is **strictly confidential** and will remain with this office. **PLEASE PRINT.**

REGISTRATION INFORMATION

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

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

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

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

Birth Date: Mo. ____ Day ____ Yr. ____

Bus. Phone: ( ) _____ - _____ Home Phone: ( ) _____ - _____

Age _____ Sex _____ Marital Status _____ May we call you at work? Yes ☐ No ☐

Employer: _____ Occupation: _____

Are other family members patients at our office? _____

Whom may we thank for referring you? _____

MEDICAL PRIORITY

Family Physician: (name) (address) Phone:( )

Are you under the care of a Medical Specialist? Yes ☐ No ☐ Type of Specialist:

(name) (address) Phone:( )

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

FINANCIAL INFORMATION

Person responsible for account: _____ Name of Spouse: _____

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

Policy No. _____ Certificate No. _____ Ins. Year end _____ Ins. Phone No. _____

Name of Subscriber: _____

Policy Holder: _____

Maximum Coverage: _____ Coverage for: Basic ____ % Major Rest. ____ % Other ____ %

METHOD OF PAYMENT

(For Office Use Only) CASH ☐ CHEQUE ☐ CREDIT CARD ☐ OTHER ☐

DENTAL HISTORY

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

	Yes	No
Is there a dental problem you would like treated immediately?	☐	☐
Date of: last dental cleaning: _____ last visit: _____ last X-rays		
1. Have you been seeing a dentist regularly?	☐	☐
2. Have you ever had any of the following?		
- Periodontal treatment? (treatment of the gums)	☐	☐
- Orthodontic treatment? (to straighten or realign teeth)	☐	☐
- A bite plate or any other appliance?	☐	☐
- Your bite adjusted or teeth ground?	☐	☐
- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	☐	☐
If you answered "**Yes**" to the last question, who performed the surgery? _____ When was it done?		
Are you being followed up by a dental specialist?	☐	☐
3. Are there any growths or sore spots in your mouth?	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?	☐	☐
5. Have you noticed any loose teeth, or, have any of your teeth shifted?	☐	☐
6. Does food catch between your teeth?	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐	☐
8. Have you been advised to take antibiotics before a dental appointment?	☐	☐
9. Do you use dental floss, proxabrush or stimudents? How often?	☐	☐
10. How often do you brush your teeth?	☐	☐
Do you feel that you have bad breath?	☐	☐
11. Have you ever experienced any of the following jaw problems:	☐	☐
- Popping/clicking in your jaw joints?	☐	☐
- Pain in your jaw joints, around your ear, or side of your face?	☐	☐
- Difficulty in opening or closing?	☐	☐
- Pain when teeth are clenched?	☐	☐
- Pain or difficulty while chewing?	☐	☐
12. Do you have any of the following habits?	☐	☐
- Clenching or grinding your teeth while awake or asleep?	☐	☐
- Biting your cheeks or lips?	☐	☐
- Mouth breathing while awake or asleep?	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)?	☐	☐
13. Do you have any emotional concerns about having dental treatment?	☐	☐
14. Are you dissatisfied with the appearance of your teeth? and, What would you like to see changed?	☐	☐
15. 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?	☐	☐