DISCOVERY DENTAL

Reset Form

Medical & Dental History Questionnaire

BEFORE YOUR APPOINTMENT (Please Print)

Title: Miss Name: _____

Date of Birth (day/month/year): _____

Home Address: _____

Suite: _____ City: _____

Province: _____ Postal Code: _____

Daytime Phone: _____

Evening Phone: _____

Business Phone: _____

Email: _____

Place of Business: _____

Occupation: _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY

Title: Miss Name: _____

Relationship: _____

Daytime Phone: _____

(1) Name of Family Doctor: _____

Phone or Address: _____

(2) Name of Specialist: _____

Area of Specialty: _____

Phone or Address: _____

Do you have Dental Insurance? ☐ Yes ☐ No

How did you hear about our office? _____

MEDICAL HISTORY: The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
☐ Yes ☐ No ☐ Not Sure/Maybe _____

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/ Maybe _____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
☐ Yes ☐ No ☐ Not Sure/Maybe _____

5. Do you have any allergies? ☐ Yes ☐ No ☐ Not Sure/Maybe
If yes, please list using the categories below:
a) medications _____
b) latex/rubber products _____
c) other (e.g. hayfever, foods) _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? ☐ Yes ☐ No ☐ Not Sure/Maybe
If yes, please explain _____

7. Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not Sure/Maybe

8. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No ☐ Not Sure/Maybe

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
☐ Yes ☐ No ☐ Not Sure/Maybe

10. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not Sure/Maybe

11. Do you have any conditions or therapies that could affect your immune system, (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ☐ Yes ☐ No ☐ Not Sure/Maybe

12. Have you ever had hepatitis, jaundice (other than at birth) or liver disease? ☐ Yes ☐ No ☐ Not Sure/Maybe

13. Do you have a bleeding problem or a bleeding disorder?
☐ Yes ☐ No ☐ Not Sure/Maybe _____

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe _____

Reset Form

15. Do you have or have you ever had any of the following? Please check.

- ☐ chest pain, angina
- ☐ heart attack
- ☐ stroke
- ☐ shortness of breath
- ☐ rheumatic fever
- ☐ mitral valve prolapse
- ☐ heart murmur
- ☐ pacemaker
- ☐ lung disease
- ☐ tuberculosis
- ☐ cancer
- ☐ steroid therapy
- ☐ diabetes
- ☐ stomach ulcers
- ☐ arthritis
- ☐ seizures (epilepsy)
- ☐ kidney disease
- ☐ thyroid disease
- ☐ organ transplant
- ☐ drug/alcohol dependency
- ☐ osteoporosis medications (e.g.Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?

☐ Yes ☐ No ☐ Not Sure/Maybe _____

17. Are there any diseases or medical problems that run in your family?(e.g. diabetes, cancer or heart disease)

☐ Yes ☐ No ☐ Not Sure/Maybe _____

18. Do you smoke or chew tobacco products?

☐ Yes ☐ No ☐ Not Sure/Maybe How many per day?_____Number of years?_____

FOR WOMEN ONLY

19. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? _____

☐ Yes ☐ No ☐ Not Sure/Maybe

DENTAL HISTORY

1. Last dental visit? _____ **2.** What was done at that visit? _____

3. How frequently do you see your dentist? _____

4. Have you ever had a full mouth series of X-rays (16 or more x-rays taken at the same time)? ☐ Yes ☐ No

If yes, approximately when? _____

5. How would you describe your dental health at present? ☐ Good ☐ Fair ☐ Poor

6. What are your present dental concerns, if any?

☐ Bleeding gums ☐ Crooked teeth ☐ Cosmetic ☐ Loose teeth ☐ Bad Breath ☐ Food Trapping
☐ Toothache ☐ Loose dentures ☐ Missing teeth/spaces Other _____

7. Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No

8. Have you had any teeth extracted due to accident, decay or gum disease? ☐ Yes ☐ No

If yes, please explain _____

9. If yes, have you had any complications after the extraction? ☐ Yes ☐ No

10. Have you been taught PREVENTIVE ORAL HYGIENE? ☐ Yes ☐ No

11. Why did you leave your last dentist? ☐ Yes ☐ No

12. What was your best experience at any previous dentist?

13. Do you have any emotional concerns regarding your dental visit?

☐ Fear ☐ Pain ☐ Time ☐ Money ☐ Embarassment

Other concerns: _____

14. Do you think you might like to have your dental treatment done while you are sedated? ☐ Yes ☐ No

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies as posted on the DicoveryDental.com website and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made, payment is due at each office visit. Unpaid accounts may be subject to interest My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist. I authorize the dentist to treat me and I assume fully responsibility for the fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

X _____ _____

SIGNATURE, PARENT OR GUARDIAN IF UNDER 18 DATE

_____ _____

DENTIST'S SIGNATURE DATE