HIGHLAND Dental Centre

NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with a standard of dental care. All information is strictly confidential and will remain in this office. Our receptionist is able to assist you with the completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

MR☐ MRS☐ MS☐ MISS☐ DR☐ THIS PATIENT IS AN: ADULT ☐ CHILD ☐

PATIENT NAME (SURNAME, GIVEN): PREFERRED NAME:

HOME ADDRESS (NO, STREET, CITY, PROVINCE): POSTAL CODE:

HOME PHONE: OTHER PHONE: EMAIL:

☐ Highland Dental Centre sends email communications which may include appointment confirmations, newsletters, upcoming events and important notifications. Check the box if you would like to receive future email communications from us.

BIRTHDATE: SEX: EMPLOYER/SCHOOL: OCCUPATION:

HOW DID YOU HEAR ABOUT US? CIRCLE ALL THAT APPLY:

Referred from a friend (Name): _____ | Website | Facebook | Ads | Other: _____

ARE YOU LIKELY TO BE AVAILABLE ON SHORT NOTICE FOR FUTURE APPOINTMENTS OR CHANGES? Yes ☐ No ☐

FAMILY PHYSICIAN: PHONE:

IN CASE OF EMERGENCY NOTIFY: RELATION: PHONE:

PERSON RESPONSIBLE FOR THIS ACCOUNT (PLEASE COMPLETE THE INFORMATION BELOW IF DIFFERENT FROM ABOVE)

SELF☐ SPOUSE☐ PARENT☐ LEGAL GUARDIAN ☐ OTHER☐

NAME (SURNAME, GIVEN) RELATION:

ADDRESS (NO, STREET, CITY, PROVINCE): PHONE:

INSURANCE INFORMATION (IF YOU HAVE A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING):

SUBSCRIBER: RELATION: INSURANCE CO:

POLICY PLAN #: DIVISION/SECT.#: SUBSCRIBER ID: SIN:

SUBSCRIBER (SECONDARY) RELATION: INSURANCE CO:

POLICY PLAN #: DIVISION/SECT.# SUBSCRIBER ID: SIN:

MEDICAL HISTORY (PLEASE ANSWER YES OR NO TO EACH QUESTION). IF YES, PLEASE SPECIFY

1. Date of last physical examination _____
2. Are you presently under the care of a physician? ..... Y ☐ N ☐ _____
3. Have you had a medical examination in the last year? ..... Y ☐ N ☐ _____
4. Do you use prescription, non-prescription, natural remedy, recreational drugs regularly? Y ☐ N ☐ _____
5. Do you have any allergic conditions? (hay fever, skin rash, food allergies, metal, latex) ..... Y ☐ N ☐ _____
6. Do allergic reactions result in headaches, shortness of breath, chest constriction, nausea? Y ☐ N ☐
7. Have you been hospitalized in the last 5 years? ..... Y ☐ N ☐ _____
8. Have you ever experienced any unusual reaction to the following? Please circle: Y ☐ N ☐ _____
   Local anesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine
9. Have you been warned against taking any drug or medication? ..... Y ☐ N ☐ _____
10. Do you bruise easily or bleed abnormally? ..... Y ☐ N ☐ _____

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MEDICAL HISTORY (PLEASE ANSWER YES OR NO TO EACH QUESTION). IF YES, PLEASE SPECIFY.

11. Have you ever had any organ or joint implants/replacement..... Y ☐ N ☐ _____
12. Have you ever fainted?..... Y ☐ N ☐ _____
13. Do your ankles, feet or hands swell?..... Y ☐ N ☐ _____
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?.....Y ☐ N ☐ _____
15. Do you have frequent headaches?..... Y ☐ N ☐ _____
16. Do you have A.I.D.S or have you ever tested positive for H.I.V? .....Y ☐ N ☐ _____
17. Do you have Hepatitis A, B or C?..... Y ☐ N ☐ _____
18. Do you have prosthetic limbs? ..... Y ☐ N ☐ _____
19. Do you have any of the following?:

☐Arthritis or Rheumatism
☐Cholesterol (hardening of arteries)
☐Cold Sores
☐Cortisone/Steroid Therapy
☐Diabetes
☐Drug/Alcohol Dependency
☐Epilepsy or Seizures
Heart related issues including:
- ☐Heart Attack
- ☐Heart Defects

☐Heart Murmur
☐Pacemaker
☐Prosthetic heart valves
☐Heart pain/angina
☐Abdominal Aortic Aneurysm
☐High/Low Blood Pressure
☐Hyper (hypo) Glycemia
☐Jaundice
☐Joint Resurfacing
☐Kidney Disease
☐Liver Diseases

☐Lung Disease (Asthma, Emphysema, COPD)
☐Mental or Nervous Disorder
☐Radiation/Chemotherapy
☐Sexually Transmitted Diseases
☐Sinus Trouble
☐Stroke
☐Stomach/Intestinal problems
☐Thyroid Disease
☐Tuberculosis
Other:_____

20. Have you had any injury, surgery, or x-ray therapy to your face or jaws?..... Y ☐ N ☐ _____
21. Do you have any disease, condition or problem that you think the doctor should know about? Y ☐ N ☐ _____
22. WOMEN ONLY: Are you pregnant or suspect you might be? If so, what month are you in? ..... Y ☐ N ☐ _____
    Are you taking birth control pills?..... Y ☐ N ☐ _____

DENTAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION) IF YES, PLEASE SPECIFY:

1. Is there a dental problem you would like to take care of as soon as possible? ..... Y ☐ N ☐ _____
2. Do you have difficulty swallowing? ..... Y ☐ N ☐ _____
3. Have you been visiting the dentist regularly? ..... Y ☐ N ☐ _____
4. Last dental visit: _____ Last cleaning: _____ Full mouth x-rays: _____
5. How often do you brush your teeth? _____ Floss your teeth? _____
6. Do your gums bleed regularly? ..... Y ☐ N ☐ _____
7. Are your teeth sensitive to: Hot☐ Cold☐ Biting☐ Sweets☐? ..... Y ☐ N ☐ _____
8. Do you feel you have bad breath at times ..... Y ☐ N ☐ _____
9. Have you ever had jaw joint surgery? ..... Y ☐ N ☐ _____
10. Do you have pain in your jaw joints or suffer from migraine headaches?..... Y ☐ N ☐ _____
11. Does any part of your mouth hurt when clenched?..... Y ☐ N ☐ _____
12. Does your jaw crack or pop when opened widely? ..... Y ☐ N ☐ _____
13. Do you grind or clench your teeth during the day or night? ..... Y ☐ N ☐ _____
14. Do you smoke or use any other forms of tobacco? ..... Y ☐ N ☐ _____
15. Have you ever experienced any growths or sore spots in your mouth? If so, where? ..... Y ☐ N ☐ _____
16. Previous problems with dental treatment? ..... Y ☐ N ☐ _____
17. Are you satisfied with the appearance of your teeth? ..... Y ☐ N ☐ _____
18. Please list any other dental concerns on questions: _____

Office Policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we will require 48 hours' notice, otherwise it may be necessary to charge for the time lost.

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

_____ _____ _____

(Signature) PATIENT☐ PARENT☐ GUARDIAN☐ DATE REVIEWING DENTIST