ARBOUR LAKE
DENTAL CARE

NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

PATIENT NAME (SURNAME, GIVEN): **PREFERRED NAME:**

BIRTHDATE (DD/MM/YY): SEX: SCHOOL:

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

HOME PHONE: OTHER PHONE: CONTACT EMAIL:

May we leave a voicemail regarding your appointment at these numbers? Yes ☐ No ☐

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

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

FAMILY PHYSICIAN: PHONE:

IN CASE OF EMERGENCY NOTIFY: RELATION: PHONE:

PARENT/GUARDIAN/CAREGIVER 1 INFORMATION:

NAME (SURNAME, GIVEN) RELATION:

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

OCCUPATION: WORK PHONE:

PARENT/GUARDIAN/CAREGIVER 2 INFORMATION (IF DIFFERENT THAN ABOVE):

NAME (SURNAME, GIVEN) RELATION:

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

OCCUPATION: WORK PHONE:

PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE (E.g. SCHEDULING APPOINTMENTS):

NAME: RELATION:

HOW DID YOU HEAR ABOUT US?

Referred from an existing patient or staff member (family, friend or colleague), internet, community, professional referral (another health care professional), emergency/walk-in or other:

Office Policy: Your appointment time will be reserved 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.

(Signature) PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ DATE

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INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING):

SUBSCRIBER:	RELATION:	INSURANCE CO:
POLICY PLAN #:	DIVISION/SECT.#:	SUBSCRIBER ID:
SUBSCRIBER (SECONDARY)	RELATION:	INSURANCE CO:
POLICY PLAN #:	DIVISION/SECT.#	SUBSCRIBER ID:

PATIENT DENTAL HISTORY

1. Reason for today's visit: _____
2. Does the patient have a dental problem that needs to be addressed as soon as possible? ..... Y ☐ N ☐ O ☐
3. Has the patient been visiting the dentist regularly? ..... Y ☐ N ☐ O ☐
4. Last dental visit: _____ Cleaning: _____ Full mouth x-rays: _____
5. How often does the patient brush his/her teeth? _____ Floss his/her teeth? _____
6. Do the patient's gums bleed regularly? ..... Y ☐ N ☐ O ☐
7. Are the patient's teeth sensitive to: ..... Hot ☐ Cold ☐ Biting ☐ Sweets ☐ Sour ☐ N/A ☐
8. Does the patient feel any pain in his/her teeth? ..... Y ☐ N ☐ O ☐
9. Has the patient ever had any head, neck or jaw injuries? ..... Y ☐ N ☐ O ☐
10. Has the patient ever had jaw joint surgery? ..... Y ☐ N ☐ O ☐
11. Does the patient have difficulty swallowing? ..... Y ☐ N ☐ O ☐
12. Does any part of the patient's mouth hurt when clenched? ..... Y ☐ N ☐ O ☐
13. Does the patient's jaw crack, click or pop when opened widely? ..... Y ☐ N ☐ O ☐
14. Does the patient grind or clench his/her teeth during the day or night? ..... Y ☐ N ☐ O ☐
15. Does the patient bite his/her lips/cheeks frequently? ..... Y ☐ N ☐ O ☐
16. Has the patient ever experienced any growths, lumps or sore spots in his/her mouth? ..... Y ☐ N ☐ O ☐
17. Has the patient noticed any loosening/movement of his/her teeth? ..... Y ☐ N ☐ O ☐
18. Has the patient had periodontal (gum) treatment? ..... Y ☐ N ☐ O ☐ If yes, date completed: _____
19. Has the patient had orthodontic treatment? ..... Y ☐ N ☐ O ☐ If yes, date completed: _____
20. Has the patient ever had treatment by a dental specialist? Y ☐ N ☐ O ☐ If yes, please specify: _____
21. Has the patient had previous problems with dental treatment? ..... Y ☐ N ☐ O ☐
22. Is the patient satisfied with the appearance of his/her teeth? ..... Y ☐ N ☐ O ☐
23. Is the patient nervous during dental treatment? ..... Y ☐ N ☐ O ☐
24. Please list any other information that you feel we should have to provide the patient with the best possible dental care:

_____

_____ _____

(Signature) PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ DATE

_____ _____

(Reviewed By Dentist): DATE

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MEDICAL HISTORY (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

1. Is the patient in good health? ..... Y ☐ N ☐ O ☐
   If no, please provide details:

2. Has there been any change in the patient's general health or weight in the past year? ..... Y ☐ N ☐ O ☐
   If yes, please explain:

3. Is the patient currently being treated for any medical condition or has he/she been treated in the last year?
   ..... Y ☐ N ☐ O ☐
   If yes, please explain:

4. When was the last time the patient had a medical examination? _____
   Were any problems identified? ..... Y ☐ N ☐ O ☐
   If yes, please explain:

5. Has the patient ever been hospitalized for any illnesses or operations? ..... Y ☐ N ☐ O ☐
   If yes, please provide details:

6. Is the patient taking any medications, non-prescription drugs or herbal supplements of any kind? Y ☐ N ☐ O ☐
   If yes, please list and provide reason for taking:

7. Does the patient have any allergies? ..... Y ☐ N ☐ O ☐
   If yes, please list using the categories below:
   Medications _____
   Latex/rubber products _____
   Other (e.g. hay fever, foods) _____

8. Has the patient had a peculiar or adverse reaction to any medicines, injections or dental local anaesthetic?
   ..... Y ☐ N ☐ O ☐
   If yes, please explain:

9. Has the patient experienced any new symptoms such as a cough or illness since recent travel or otherwise? Y ☐ N ☐ O ☐
   If yes, please explain:

10. Does the patient have or has the patient ever had a replacement or a 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?
    ..... Y ☐ N ☐ O ☐
    If yes, please explain:

11. Has the patient ever been advised to take antibiotic pre-medication prior to dental treatment? .. Y ☐ N ☐ O ☐
    If yes, please explain:

MEDICAL HISTORY CONTINUED ON NEXT PAGE

ARBOUR LAKE DENTAL CARE

MEDICAL HISTORY (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

12. Does the patient have a prosthetic or artificial joint? ..... Y ☐ N ☐ O ☐
If yes, please explain:

13. Does the patient have any conditions or is the patient undergoing any therapies that could affect his/her immune system?
(E.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)..... Y ☐ N ☐ O ☐
If yes, please explain:

14. Has the patient ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders?..... Y ☐ N ☐ O ☐
If yes, please explain:

15. Does the patient have a bleeding problem, bleeding disorder or bruising tendency?..... Y ☐ N ☐ O ☐
If yes, please explain:

16. Does the patient have any or has the patient ever had any of the following (circle all that apply):

a. Fainting / Dizzy spells
b. Eating disorder
c. Stroke
d. Rheumatic fever
e. Mitral valve prolapse
f. Heart problems, murmur
g. Asthma or Emphysema
h. Pacemaker
i. Lung disease
j. Tuberculosis
k. Cancer
l. Steroid therapy
m. Diabetes
n. Stomach ulcers
o. High blood pressure
p. Arthritis / Rheumatism
q. Seizures / Epilepsy
r. Kidney disease
s. Thyroid disease
t. High / Low blood pressure
u. Hyper / Hypoglycemia
v. Mental or Nervous disorder
w. Circulatory problems
x. Blood transfusion
y. Other communicable disease / Transmissible infection

17. Are there any conditions or diseases not listed above that the patient has or has had?..... Y ☐ N ☐ O ☐
If yes, please provide details:

18. Is there any additional information related to the patient's health that has not been addressed above?

(Signature) PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ DATE

(Reviewed By Dentist): DATE