Bayview North
DENTAL CARE

Welcome to Our Dental Office

ID #	
MEDIC ALERT	Y ☐ N ☐

Date:

The information that is requested on this Questionnaire, Dental History and Medical History form is essential to providing you with the highest standard of the dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. **PLEASE PRINT AND COMPLETE**

REGISTRATION INFORMATION – This information will enable us to maintain communication with you.

The patient is an:

Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian:

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Name: Language Preference:

Prefers to be called:

Address:

Phone: Business Phone: Cell Phone:

Driver's Lic. No. (for Rx):

E-mail Address:

Date of Birth: Age: Gender: Marital Status:

Name of Spouse: Preferred appointment time:

Whom may we thank for referring you?

Are other family members patients at our office? Y ☐ N ☐

MEDICAL PRIORITY – This information will enable us to make any essential contacts.

Family Physician: Phone:

Medical Specialist: Phone:

In case of emergency, please contact: Phone:

Reason for today's visit? Examination ☐ Emergency ☐ Other ☐

Is there a dental problem you would like treated immediately?

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FINANCIAL INFORMATION – This information is necessary to process an invoice and apply payments

Person responsible for account: Self ☐ Spouse ☐ Other ☐ Please complete all information if different from above.

The patient is an:

Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian:

Name: Address:

Home Phone: Bus. Phone: Cell Phone:

Drivers Lic. No.

METHOD OF PAYMENT*(for office use only)* CASH ☐ CHEQUE ☐ CREDIT ☐ DEBIT ☐

PRIMARY DENTAL INSURANCE*(if required by office)*

Subscribers Name:

D.O.B.:

Emp./Grp. Policy Holder:

Ins. Co.

Grp./Ind. Policy No.

Cert. No.

Tel.:

Ins. Yr. End:

Max Coverage:

% coverage:

Basic ☐ Maj. Rest. ☐ Ortho. ☐ Other ☐

SECONDARY DENTAL INSURANCE

Subscribers Name:

D.O.B.:

Emp./Grp. Policy Holder:

Ins. Co.

Grp./Ind. Policy No.

Cert. No.

Tel.:

Ins. Yr. End:

Max Coverage:

% coverage:

Basic ☐ Maj. Rest. ☐ Ortho. ☐ Other ☐

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Please check Yes or No to each question. If unsure of a question, please consult with the dentist.

		YES	NO
1.	Are you being treated for any medical condition at present or within the past two years? If Yes, explain.	☐	☐
2.	Have you been hospitalized in the past two years?	☐	☐
3.	When was your last visit to a physician? Last examination?	☐	☐
4.	Have you recently, or are you presently taking any prescription or non-prescription drugs? (list them)	☐	☐
5.	Have you ever reacted adversely to any medications or injections? (Please Circle) Penicillin, other antibiotics, aspirin, codeine, local anaesthetic, nitrous oxide, other medications	☐	☐
6.	Have you been advised against taking specific medication?	☐	☐
7.	Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic condition?	☐	☐
8.	Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain:	☐	☐
9.	Is there a family history of Diabetes, Cancer, or Heart Disease?	☐	☐
10.	Do you bleed excessively from acute injury, or bruise easily?	☐	☐
11.	Do your ankles, feet or hands swell?	☐	☐
12.	Has your weight, appetite or energy level changed dramatically recently?	☐	☐
13.	Do you follow a special diet or are you on a diet pill therapy?	☐	☐
14.	Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
15.	Have you tested HIV positive?	☐	☐
16.	Do you have frequent severe headaches, earaches or ear/throat infections?	☐	☐
17.	Have you ever had an injury or surgery to your face or jaws?	☐	☐
18.	Do you wear eyeglasses or contact lenses?	☐	☐
19.	Do you have any hearing difficulties?	☐	☐
20.	Do you smoke or use any other forms of tobacco?	☐	☐
	Are you wearing the transdermal nicotine patch?	☐	☐
21.	Are you alcohol and/or drug dependent?	☐	☐
	If Yes, have you received treatment?	☐	☐

22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

AIDS	☐	☐	Glaucoma	☐	☐	Lupus	☐	☐
Anemia	☐	☐	Head/Neck Injuries	☐	☐	Malignant Hyperthermia	☐	☐
Angina Pectoris	☐	☐	Heart Disease or Attack	☐	☐	Mental/Nervous Disorder	☐	☐
Arthritis/Rheumatism	☐	☐	Heart Murmur	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart Pacemaker	☐	☐	Organ transplant/medical implant	☐	☐

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Artificial joints (hip, knee)	☐	☐	Heart Rhythm Disorder	☐	☐	Psychiatric Treatment	☐	☐
Blood disorders	☐	☐	Heart Surgery	☐	☐	Radiation treatment / chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis A, B or C	☐	☐	Scarlet fever / Rheumatic fever	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Sickle cell disease	☐	☐
Circulation problems	☐	☐	High or Low blood pressure	☐	☐	Sinus trouble	☐	☐
Congenital heart lesions	☐	☐	Hodgkin's Disease	☐	☐	Stomach / Intestinal problems / Ulcers	☐	☐
Cortisone / steroid	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Stoke	☐	☐
Crohn's Disease	☐	☐	Hypertension	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Inflammatory Bowel Disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Jaundice	☐	☐	Venereal Disease	☐	☐
Epilepsy or seizures	☐	☐	Kidney Disease	☐	☐	COVID-19	☐	☐
Fainting or dizzy spells	☐	☐	Liver Disease	☐	☐	Other	☐	☐
Glandular Disorders	☐	☐	Lung Disease	☐	☐	Other	☐	☐

23. Has the CHILD PATIENT recently had any of the following *(Please indicate approximate date)*

Measles	☐	☐	Mumps	☐	☐
Chicken Pox	☐	☐	Tonsillitis	☐	☐
Strep Throat	☐	☐	Other	☐	☐

24. Do you currently have, or have you had, any disease, condition or problem not listed above?	☐	☐
25. Is there anything else about your health we should be made aware of?	☐	☐
26. Do you wish to speak privately to the Doctor about any problem or medical condition?	☐	☐

27. WOMEN ONLY:

Are you pregnant or suspect you may be? Y ☐ N ☐ Expected delivery date?

Are you breastfeeding? Y ☐ N ☐

Are you taking birth control pills? Y ☐ N ☐

WOMEN OVER 50: Are you aware of your bone mineral density? Y ☐ N ☐

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DENTAL HISTORY

Please check Yes or No to each question. If unsure of a question, please consult with the dentist.

Is there a dental problem you would like treated immediately? Y ☐ N ☐

Date of your last visit: Last Cleaning: Last X-Rays:

	YES	NO
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?	☐	☐
- Oral Surgery (surgery in or around the mouth/jaw joint, or implant surgery in oneor both of your jaw joints)? If you answered yes to the question above, who performed the surgery and when?	☐	☐
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 teethor 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 Stim-U-Dents? How often?	☐	☐
10. Do you brush your teeth often?	☐	☐
11. Do you feel like you have bad breath?	☐	☐
12. Have you ever experienced the following jaw problems?		
- Popping/clicking in your jaw joints?	☐	☐
- Difficulty with opening or closing?	☐	☐
- Pain when teeth are clenched?	☐	☐
- Pain or difficulty while chewing?	☐	☐
13. Do you have the following habits?		
- Clenching or grinding your teeth while awake or asleep?	☐	☐
- Mouth breathing while awake or asleep?	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)?	☐	☐
14. Have you ever had an upsetting experience in a dental office, or any complication during or following dental treatment, or, do you have any questions or concerns?	☐	☐
15. Are you unhappy with the appearance of your teeth and would like to see them changed?	☐	☐
16. Do you feel your dental health influences your overall health?	☐	☐
17. On a scale of 1-10, 10 being highest, how important is it for you to keep your natural teeth? (circle one) 1 2 3 4 5 6 7 8 9 10		

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GENERAL RELEASE*(Please sign after completing medical questionnaire)*

I, the undersigned, certify that I have provided an accurate and complete, personal, medical and dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers 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 office as soon as possible**. I authorize the dentist to perform diagnostic procedures that may be necessary or required. I have also been advised of the privacy policy of the office andthat personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental service for myself (and my dependents, if applicable) is mine, and I assume responsibility for fees associated with these services.

Signature: Date:

Patient ☐ Parent ☐ Guardian ☐

Reviewed by Treating Dentist: