Bramwest
FAMILY DENTAL

MEDICAL ALERT

The information in this questionnaire is CONFIDENTIAL and enables our office to provide the highest level of care and service possible. Please complete the entire form as completely as possible. Thank you.

PERSONAL INFORMATION

TODAY'S DATE: _____

☐ Mr. ☐ Ms. ☐ Miss. ☐ Mrs. ☐ Dr.

NAME: _____

DATE OF BIRTH: _____
DAY MONTH YEAR

ADDRESS (HOME): _____

_____

_____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

DRIVER'S LICENSE NO.: _____

OCCUPATION: _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY…

NAME: _____

RELATIONSHIP: _____

DAY TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS: _____

_____

_____

NAME OF MEDICAL SPECIALIST:

_____

AREA OF SPECIALTY: _____

PHONE OR ADDRESS: _____

_____

EMAIL ADDRESS:

HOW DID YOU FIND OUT ABOUT OUR OFFICE:

FINANCIAL INFORMATION

PLEASE COMPLETE ALL INFORMATION IF DIFFERENT FROM PREVIOUS (ABOVE) SECTION

Person responsible for account: **Self** **Spouse** **Other** _____

Name: _____ Phone: _____

Address: _____
City Province Postal Code

Employed By: _____ Driver's License No. _____

Students:

What School are you currently attending: _____ In what city: _____

DENTAL INSURANCE

Name of Policy Holder: _____ Policy Holder Date of Birth (DD/MM/YY) ____/____/____

Insurance Company: _____ Employer: _____

Policy No.: _____ ID/Certificate No. : _____

Is there Secondary Insurance? Y/N If Yes,

Name of Policy Holder: _____ Policy Holder Date of Birth (DD/MM/YY) ____/____/____

Insurance Company: _____ Employer: _____

Policy No.: _____ ID/Certificate No. : _____

MEDICAL HISTORY QUESTIONAIRE

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? ☐ Yes ☐ No ☐ Not sure/Maybe

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? If you answered yes, please list using the categories below.
   a) Medications b) Latex/Rubber products c) Other e.g. hayfever, foods… ☐ Yes ☐ No ☐ Not sure/Maybe

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

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 heart murmur, mitral valve prolapse or rheumatic fever? ☐ Yes ☐ No ☐ Not sure/Maybe

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

11. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No ☐ Not sure/Maybe

12. Do you have any conditions or therapies that could affect your immune system e.g. Leukemia, AIDS, HIV Infection, Radiotherapy, Chemotherapy? ☐ Yes ☐ No ☐ Not sure/Maybe

13. Have you ever had hepatitis, jaundice, or liver disease? ☐ Yes ☐ No ☐ Not sure/Maybe

14. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not sure/Maybe

15. Have you ever been hospitalized for any illness or operations? If yes, please explain. ☐ Yes ☐ No ☐ Not sure/Maybe

16. Do you have or have you ever had any of the following? If yes, please explain. (Please circle)

Chest Pain, Angina	Shortness of breath	Pacemaker	Steroid therapy	Seizures (Epilepsy)
Drug/Alcohol Dependency	Heart Attack	Lung Disease	Diabetes	Kidney Disease
Stroke	Prosthetic Heart Valve	Tuberculosis	Stomach Ulcers	Thyroid Disease
Cancer	Arthritis	Diet Pill Therapy		

17. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ Yes ☐ No ☐ Not sure/Maybe

18. Are there any disease or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ Yes ☐ No ☐ Not sure/Maybe

19. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not sure/Maybe

20. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not sure/Maybe

21. **For women only:** Are you breast feeding or pregnant? If pregnant, what is the expected delivery date? ☐ Yes ☐ No ☐ Not sure/Maybe

DENTAL HISTORY QUESTIONNAIRE

Please check YES or NO to each question. If you are unsure of a question, please consult with the dentist.

Is there a dental problem you would like treated immediately? ☐ Yes ☐ No

Date of last dental visit: _____ Date of last dental cleaning: _____

Date of last dental x-rays: _____

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

OFFICE POLICIES

Anti-Spam Policy Review: When we communicate with you, we may communicate via electronic means, such as email. We strive to ensure that our communications do not contain any spam. "Spam" refers to any unsolicited Commercial Electronic Message (or CEMS) that have been sent without consent. In that light, we require all CEMs from our Office to be in compliance with Privacy Laws. If and when we communicate with you using CEMs, you can opt out of receiving such messages by following the "Unsubscribe" link included at the bottom of such messages. In the event that our Office inadvertently sends out a CEM without consent, we commit to investigating every such instance and assisting the employee(s) involved with renewing their understanding and awareness of our compliance responsibilities.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowing omitted any information. I give my permission to telephone or email me to discuss matters related to this form. I have had the opportunity to ask questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____

(Signature) Patient Parent Guardian (Print Name of Guardian)