QUEENS FAMILY DENTISTRY

Contact: 519 439 6491
www.queensfamilydentistry.ca
Email: info@queensfamilydentistry.ca

UPDATED INFORMATION

PERSONAL INFORMATION

Today's Date:_____

First Name		Last Name	
Gender	☐ Male ☐ Female ☐ Other	How would you like to be addressed?	
Address			
City		Postal Code	
Birth Date		Email	
Home Phone		Cell Phone	**Allow SMS:** ☐ YES ☐ NO
Place of Employment		Work Phone	
Emergency Contact not living with you:		Phone	

PHYSICIAN INFORMATION

Name of Physician		Phone	
Address of Physician		Date of last Physical Exam	

DENTAL INFORMATION

Are your teeth experiencing any discomfort or pain at this time?	Yes ☐ No ☐
Do you frequently get food caught between any teeth? Where?	Yes ☐ No ☐
Are you interested in: ☐ Teeth Whitening ☐ Straightening of Teeth (Invisalign) ☐ Smile transformation	
Please select if you have or have you had any of the following: ☐ **Clenching** ☐ **Grinding** ☐ **Jaw Pain** ☐ **Popping Sounds** ☐ **Limited Opening** ☐ **Locking** ☐ **Sensitivity**	

MEDICAL INFORMATION

Are you in good general health?	☐ Yes ☐ No
List **ALL** Medical Conditions and Allergies:	
Please list **ALL** current medications, **dosage** and **reason** for usage:	
Have you been hospitalized or had any serious illness or operation ever?	☐ Yes. When, what? ☐ No
Have you been out of the country or traveled for more than 10 days anywhere in 2020?	☐ Yes. Where? ☐ No

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Please select if you have had an allergic reaction or reacted to any of the following: ☐ **Local anaesthetics** ☐ **Antibiotics** ☐ **Penicillin** ☐ **Sulfa drugs** ☐ **Barbiturates** ☐ **Sedatives** **Aspirin** ☐ **Tylenol** ☐ **Sleeping Pills** ☐ **Codeine** ☐ **Demerol** ☐ **Latex (eg. rubber gloves)**

Please select if you have had any of the following: ☐ **Cardiac Pacemaker** ☐ **Tuberculosis** ☐ **Sinusitis** ☐ **Emphysema** ☐ **Chronic Bronchitis** ☐ **Asthma** ☐ **Sinus trouble** ☐ **Stomach ulcers** ☐ **Hepatitis** ☐ **HIV** ☐ **Jaundice** **Diabetes** ☐ **Thyroid trouble** ☐ **Anemia** ☐ **Sickle Cell disease** ☐ **Blood disorders** ☐ **Hemophilia** ☐ **Glaucoma**

Do you have chest pain after exertion? ☐ Yes ☐ No

Please select if have ever had: ☐ **Epilepsy** ☐ **Fainting Spells** ☐ **Seizures** ☐ **Emotional disturbance**

Are you currently under physician's care for anything? ☐ Yes ☐ No

Is there any family history of blood disorders? ☐ Yes ☐ No

Have you had abnormal bleeding after any surgery, extraction or trauma? ☐ Yes ☐ No

Have you ever had a blood transfusion? When? ☐ Yes ☐ No

Please select if you have or have you ever had? ☐ **Arthritis** ☐ **Inflammatory Rheumatism** ☐ **Bone Infection** ☐ **Osteoporosis** ☐ **Kidney trouble** **Venereal disease** ☐ **Exposure to HIV virus** **AIDS** ☐ **Tumor** ☐ **Chemotherapy** ☐ **Radiation therapy** ☐ **Cancer** ☐

Do you have artificial joints? What and date of placement: ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes. How many times per day? ☐ No

Do you drink alcohol? ☐ Yes. How much in a week? ☐ No

Do you consume any recreational substances? ☐ Yes. What and how often? ☐ No

Are you pregnant or nursing? ☐ Yes. How many weeks? ☐ No

Is there anything in your medical and dental history that we have not specifically asked about that we should be made aware of? If so, Please explain.

_____

RESPONSIBILITY & CONSENT FORM

I hereby authorize and request the performance of dental services for myself or any of my dependents. I also give my consent to the advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for dental treatment or diagnostic purpose. These records may include study models, photographs or x-rays. I understand and acknowledge that I am financially responsible for the services provided for myself or any of my dependants, regardless of the insurance coverage. I also understand that the treatment estimate presented to me is only an estimate and occasionally, the need may arise to modify treatment. I believe the information given in the previous pages of the medical and dental history to be true to the best of my knowledge.

Signature of Patient or Guardian: _____ Date : _____