QUEENS FAMILY DENTISTRY

Phone: (519) 439-6491
info@queensfamilydentistry.ca

NEW PATIENT

MEDICAL AND DENTAL HISTORY

PERSONAL INFORMATION

Date of First Visit			
First Name		Last Name	
Please Circle One	Male Female	Mr. Mrs. Miss. Dr.	
Address			
City		Postal Code	
Birth Date		Email	
Home Phone		Cell Phone	
Place of Employment		Work Phone	
Occupation			
Emergency Contact not living with you		Phone	
How did you hear about us?			

PHYSICIAN INFORMATION

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

DENTAL INSURANCE INFORMATION

Primary Insured's Name		DOB of Insured	
Insurance Company Name		Insured Employer	
Group Number		ID Number	

Secondary Insured's Name		DOB of Insured	
Insurance Company Name		Insured Employer	
Group Number		ID Number	

I authorize release, to my insuring company plan administrator, the information contained in the claim submitted electronically.

Signed of Patient or Guardian: ______________________________

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DENTAL INFORMATION

Name of your previous Dentist :	
City and Phone Number:	
Date of your last dental cleaning?	Month: Year:
What is your main concern or dental problem?	
Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)	1 2 3 4 5 6 7 8 9 10
I routinely see my dentist every:	3 mo. 4 mo. 6 mo. 9mo. 12 mo. Not routinely

Question	Yes	No
Are you experiencing any discomfort or pain at this time?	❏ Yes	❏ No
Are you satisfied with the appearance of your teeth?	❏ Yes	❏ No
Have you ever had complications from past dental treatment? If Yes, Explain:	❏ Yes	❏ No
Have you ever had trouble getting numb or had any reactions to local anesthetic?	❏ Yes	❏ No
Do your gums bleed or are they painful when brushing or flossing?	❏ Yes	❏ No
Do you frequently get food caught between any teeth? Where?	❏ Yes	❏ No
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	❏ Yes	❏ No
Do you clench or grind your teeth that makes them sore?	❏ Yes	❏ No
Do you have headaches, earaches, or neck pain?	❏ Yes	❏ No
Do you wear or have you ever worn a bite appliance?	❏ Yes	❏ No
Have you ever whitened (bleached) your teeth?	❏ Yes	❏ No
Do you have partial or complete dentures? If yes, what and when were they made?	❏ Yes	❏ No
Do your dentures hurt or move during function?	❏ Yes	❏ No

MEDICAL INFORMATION

Question	Yes	No
Are you in good general health?	❏ Yes	❏ No

Please list all current medications, dosage and reason for usage:

Please list all Allergies:

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MEDICAL INFORMATION CONTINUED

Question	Yes	No
Are you now under a physician care? If yes, for what condition?	❑ Yes	❑ No
Have you had any serious illness or operation? If yes, for what condition?	❑ Yes	❑ No
Have you been hospitalized within the last 5 years? If yes, for what reason?	❑ Yes	❑ No
Please circle if you have or have you had any of the following disease(s): **Heart murmur** **Rheumatic heart** **Heart trouble** **Heart attack** **Stroke** **Coronary insufficiency** **Damaged heart valves** **Congenital heart disease**		
Do you have chest pain after exertion?	❑ Yes	❑ No
Do you have a cardiac pacemaker?	❑ Yes	❑ No
Do you have any blood pressure problems controlled by medication? High or Low	❑ Yes	❑ No
Please circle have ever had: **Epilepsy** **Fainting Spells** **Seizures** **Emotional disturbance**		
Do you follow any treatment for behavioural diseases?	❑ Yes	❑ No
Do you have a persistent cough or cold?	❑ Yes	❑ No
Do you have or have you ever had Tuberculosis?	❑ Yes	❑ No
Please circle have ever had: **Sinusitis** **Emphysema** **Chronic** **Bronchitis** **Asthma** **Sinus trouble** **Stomach ulcers** **Hepatitis** **HIV** **Jaundice** **Diabetes** **Thyroid trouble** **Anemia** **Sickle Cell disease** **Blood disorders** **Hemophilia**		
Is there any family history of blood disorders?	❑ Yes	❑ No
Have you bed abnormal bleeding after any surgery, extraction or trama?	❑ Yes	❑ No
Have you ever had a blood transfusion? When?	❑ Yes	❑ No
Please circle 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 circle 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? (eg. Knee, hip etc.)	❑ Yes	❑ No
Do you have glaucoma?	❑ Yes	❑ No
Do you smoke or use tobacco?	❑ Yes	❑ No
Are you pregnant or nursing?	❑ Yes	❑ No

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----------------------IMPORTANT--------------------------

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: ____

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RESPONSIBILITY & CONSENT FORM

I hereby authorize and request the performance of dental services for my or any of my dependants. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purpose or dental treatment. 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. Occasionally, the need may arise to modify treatment. In such case, I will be informed of the need for additional treatment and its fees. 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 : ____________________________

Previous Dental Records Request

This authorizes to release your dental records in accordance with Royal College of Dental Surgeons of Ontario guidelines to Queens Family Dentistry.
Release all legal responsibility or liability from your previous dentist listed below.

Previous Dentist: ____________________ Phone: ______________________

Requesting Records for: _________________________________ DOB: ___________________

- ❏ Copy of Records of Completed Treatment with in the past 10 years
- ❏ Radiographs within 3 years
- ❏ Copy of Odontogram
- ❏ Copy of ongoing Treatment Plan and outstanding recommended work
- ❏ Dates of :
  - NPE Exam Date ____
  - RC Scaling & Polish Date _________________________________
  - BW Date ____
  - PAN Date ____

Signature of Patient or Guardian: ______________________________ Date : _____________________

Please email records to info@queensfamilydentistry.ca