QUEENS FAMILY DENTISTRY

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

# MEDICAL AND DENTAL HISTORY

## PERSONAL INFORMATION

| First Name | | Last Name | |
|---|---|---|---|
| Please Circle One | Male Female | Mr. Mrs. Miss. Dr. | |
| Address | | | |
| City | | Postal Code | |
| Birth Date (MM/DD/YYYY) | | Email | |
| Home Phone | | Cell Phone | |
| Occupation | | Employer | |
| Emergency Contact: | | Phone# ( ) - | |
| Name of General Physician | | Phone | |
| Do you have any other physicians that you are under their care? If yes provide their Name and Phone Numbers: | | | |

## DENTAL INFORMATION

| **Primary** Insured's Name | | DOB of Insured | |
|---|---|---|---|
| Insurance Company Name | | Relation of Member: | |
| Group Number | | ID Number | |
| **Second** Insured's Name | | DOB of Insured | |
| Insurance Company Name | | Relation of Member: | |
| Group Number | | ID Number: | |

I authorise claims submitted electronically and any additional information required by my insurance company.
Signed of Insurance Member or Guardian: ____________________________________________

| Name Phone Number of your previous Dentist : | ( ) - . |
|---|---|
| Date of your last dental cleaning? | Month: _______ Year: _______ |
| I routinely see my dentist every: | 3 mo. 4 mo. 6 mo. 9 mo. 12 mo. Not routinely. |

| Have you ever taken prophylactic antibiotics before dental appointments? If yes, why? | ❑ No |
|---|---|
| Have you ever had complications from past dental treatment? If Yes, Explain: | ❑ No |

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| Are you experiencing any discomfort or pain at this time? If Yes, Explain: | ❑ No |
|---|---|
| Have you ever had trouble getting numb to local anesthetic? If Yes, Explain: | ❑ No |
| Do you get food caught/pain/bleeding when brushing or flossing? If Yes, Explain: | ❑ No |
| Have you had jaw:**-pain -sounds -limited opening -locking -popping -clenching -grinding -worn a bite appliance** | |
| Do you have partial or complete dentures? If yes, what and when were they made? | ❑ No |
| Any interested in: Whitening or Straightening of Teeth (Invisalign) | ❑ No |

## MEDICAL INFORMATION

| List **ALL** current medications name: | dosage | reason for use: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have had an allergic reaction or reacted to any of the following: **Local anaesthetics -Antibiotics -Penicillin -Sulfa drugs-Sedatives -Aspirin -Tylenol - Sleeping pills -Codeine -Demerol -Latex**
Please list **ALL** Allergies:

| Are you in good General Health? | ❑ Yes ❑ No |
|---|---|

Please circle if you have or have you had any of the following? **-Heart murmur -Rheumatic heart -Heart trouble -Heart attack -Stroke -Coronary insufficiency -Damaged heart valves -Congenital heart disease -Epilepsy -Fainting Spells -Seizures -Cardiac Pacemaker -Tuberculosis -Blood Pressure High/ Low -Sinusitis -Emphysema -Chronic Bronchitis -Asthma -Stomach ulcers -Hepatitis -HIV -AIDS -Jaundice -Diabetes -Thyroid trouble -Anaemia -Sickle Cell Disease -Haemophilia -Blood Transfusion - Arthritis -Inflammatory Rheumatism -Bone Infection -Osteoporosis -Kidney trouble -STD -Tumour -Cancer -Chemotherapy -Radiation -Artificial joints -Glaucoma -Pregnant -Breastfeeding** If Yes, Explain:

| Do you follow any treatment for behavioural disorder? If Yes, Explain: | ❑ No |
|---|---|
| Do you smoke or use tobacco or drink alcohol? If yes, how much? | ❑ No |
| Do you consume any recreational substances? If yes, what and how often? | ❑ No |
| Are you pregnant or nursing? If Yes, Explain: | ❑ Yes ❑ No |

Is there anything in your medical and dental history that we have not specifically asked or you need to elaborate about that we should be made aware of ? If so, Please explain: ______________________________

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## RESPONSIBILITY & CONSENT FORM

I hereby authorise and request the performance of dental services for my or any of my dependents. I also give my consent to any advisable and necessary dental procedures, medications, or anaesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes 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 dependents, regardless of the insurance coverage. I also understand that the treatment estimate presented to me is only an estimate. 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 authorises to release your dental records in accordance with the 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: __________________ Email: _______________________________

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 _________________________________________________
- Cancel any scheduled appointments

Signature of Patient or Guardian: ________________________________ Date : _______________________

Please email records to info@queensfamilydentistry.ca