One Centre Dentistry

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First Name________________________Last name_______________________________ Age_____Date of birth___________

Home address____Apt. #___________Postal code _______________

Home No.________________________ Work No.________________________Cell No.______________________________

Email____

Your occupation __________________________________ Employer ____

How did you hear about us (ie. patient, internet, etc.)? ____

If you have dental insurance, please complete the following:

Name of insured _______________________________ Relationship to insured_____________________________________

Group policy No.______________________________Certificate No. or ID No._____________________________________

Do you have a secondary insurance? ____

Emergency contact person: name: ___________________________________ Contact number_________________________

MEDICAL AND DENTAL HEALTH QUESTIONNAIRE

The following information is requested to enable us to give you the most consideration of your time and feelings. In order for any doctor to thoroughly diagnose any condition he must have accurate answers so that he may give personal attention to each individual. This information, important for our records and your health is, of course, confidential. Please fill in the following form completely.

DENTAL HISTORY

Have you ever had a thorough dental examination with a complete series of x-ray photographs (10 or more) of your teeth?
____ Date_______________________________________

Last Dental Visit (date if possible) ___________________________ Were x-ray taken? _________________________________

What dental condition (if any) concerns you at present? ____

What is the history of this condition? ____

Have you had regular (annual or semi-annual) dental examinations in the past? _____________________________________

Have you had any teeth extracted due to accident, decay or gum disease (underline)? _________________________________

Have you ever been given local anesthetic (freezing)? ______________Were you affected normally? ____________________

Do you experience bad breath/bad taste? ____

Do your gums bleed when brushing? ____

Do your gums ever feel tender or swollen? ____

Do you chew easily and thoroughly? ____

Do you favour one side when chewing? ____

Do you grind or clench your teeth? ____

Are you tense during dental visits? ____

Are you satisfied with the appearance of your teeth? ____

Do you consider your teeth beyond treatment? ____

MEDICAL HISTORY

Who is your physician? ____

Last Visit? _____________________________Purpose?____

Have you ever had a serious illness? ____

Do you use day medicine regularly? Please list: ____

Have you ever had or been treated for:

	yes	no		yes	no
Heart Attack or Heart Disease	□	□	Arthritis or Joint Problems	□	□
Pacemaker	□	□	Cancer	□	□
Rheumatic Fever	□	□	Blood Disorders	□	□
Abnormal Blood Pressure	□	□	Prosthesis	□	□
Tuberculosis or Lung Disease	□	□	Anemia	□	□
Sinusitis	□	□	Mental or Nervous Disease	□	□
Kidney Disease	□	□	Epilepsy	□	□
Jaundice or Liver Disease	□	□	Stroke	□	□
Diabetes	□	□	Hay Fever	□	□
Thyroid	□	□	Asthma	□	□
Gall Bladder	□	□	Allergies	□	□
Stomach Ulcer	□	□	HIV/AID	□	□

Have you experienced any unusual reaction to any of the following drugs:

	yes	no		yes	no
Aspirin	□	□	Barbiturates (Sleeping Pills)	□	□
Penicillin	□	□	Latex	□	□
Sulfanomide (Sulfa)	□	□	Other: ______________________________		
Have you ever fainted?	□	□	______________________________		

Do you experience shortness of breath after mild exertion?___________________Pains in Chest?_______________________

Do you require an extra pillow when you recline or sleep?___________________Do your ankles swell?__________________

Has your weight changed recently? ____

Are you now or have you ever been on a diet prescribed by your doctor? ____

If yes, for what reason? ____

Do you bruise easily or bleed abnormally? ____

Have you ever had an injury, surgery, or x-ray therapy on your face or jaws? ____

WOMEN ONLY: Are you pregnant? _____________________

Do you wish to talk to the dentist privately about any problem? ____

I, the principal policy holder of the above insurance plan, give ONE CENTRE DENTISTRY authorization to release information to my insurance company. To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

____________________________________ ____________________________

patient signature date