MILLWOODS
TOWN CENTRE DENTAL CLINIC

NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

PATIENT NAME (SURNAME, GIVEN): _____

PREFERRED NAME: _____

BIRTHDATE (DD/MM/YY): _____ SEX/GENDER: _____ HEIGHT/WEIGHT: _____

SCHOOL/OCCUPATION: _____

HOME ADDRESS (Nº, STREET, CITY, PROVINCE): _____

_____

POSTAL CODE: _____ HOME PHONE: _____ OTHER PHONE: _____

CONTACT EMAIL: _____

May we leave a voicemail regarding your appointment at these numbers? Yes ☐ No ☐

Are you likely to be available on short notice for future appointments or changes? Yes ☐ No ☐

We would like to send you email and text communications which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us. ☐

IN CASE OF EMERGENCY NOTIFY: _____

RELATION: _____ PHONE: _____

FAMILY PHYSICIAN: _____ PHONE: _____

NAME OF MEDICAL SPECIALIST: _____ AREA OF SPECIALTY: _____

PHONE OR ADDRESS: _____

NAME OF MEDICAL SPECIALIST: _____ AREA OF SPECIALTY: _____

PHONE OR ADDRESS: _____

PARENT/GUARDIAN/CAREGIVER 1 INFORMATION

NAME (SURNAME, GIVEN): _____

RELATION: _____

ADDRESS (Nº, STREET, CITY, PROVINCE): _____ PHONE: _____

OCCUPATION: _____ WORK PHONE: _____

PARENT/GUARDIAN/CAREGIVER 2 INFORMATION (IF DIFFERENT THAN ABOVE)

NAME (SURNAME, GIVEN): _____

RELATION: _____

ADDRESS (Nº, STREET, CITY, PROVINCE): _____ PHONE: _____

OCCUPATION: _____ WORK PHONE: _____

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PATIENT NAME: _____

PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE

(E.G. SCHEDULING APPOINTMENTS)

NAME: _____ RELATION: _____

HOW DID YOU HEAR ABOUT US?

- ☐ Friend
- ☐ Family member
- ☐ Colleague
- ☐ Staff member at our office
- ☐ Patient at our office
- ☐ Referral from health professional
- ☐ Website/Internet
- ☐ Advertisement
- ☐ Saw sign/Office in person
- ☐ Other: _____

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

_____ _____

Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING)

SUBSCRIBER: _____

RELATION: _____

INSURANCE CO: _____

POLICY PLAN #: _____

DIVISION/SECT.#: _____

SUBSCRIBER ID: _____

SUBSCRIBER: (SECONDARY) _____

RELATION: _____

INSURANCE CO: _____

POLICY PLAN #: _____

DIVISION/SECT.#: _____

SUBSCRIBER ID: _____

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PATIENT NAME: _____

PATIENT DENTAL HISTORY

1. Reason for today's visit:

_____

2. Do you have a dental problem that needs to be addressed as soon as possible? ..... Yes ☐ No ☐
3. Have you been visiting the dentist regularly? Yes ☐ No ☐
4. Last dental visit _____ Cleaning _____ X-rays _____
5. How often do you brush your teeth? Floss your teeth? _____
6. Do your gums bleed regularly? ..... Yes ☐ No ☐
7. Are your teeth sensitive to ..... Hot ☐ Cold ☐ Biting ☐ Sweets ☐ Sour ☐ N/A ☐
8. Do you feel any pain in your teeth? ..... Yes ☐ No ☐
9. Have you ever had any head, neck, or jaw injuries/surgery? ..... Yes ☐ No ☐
10. Do you have dry mouth or difficulty swallowing? ..... Yes ☐ No ☐
11. Do you snore or have sleep apnea? ..... Yes ☐ No ☐
12. Does your jaw crack, click or pop when opened widely? ..... Yes ☐ No ☐
13. Do you grind or clench your teeth during the day or night? ..... Yes ☐ No ☐
14. Do you bite your lips/cheeks frequently? ..... Yes ☐ No ☐
15. Have you ever experienced any growths, lumps or sore spots in your mouth? ..... Yes ☐ No ☐
16. Have you noticed any loosening/movement of your teeth? ..... Yes ☐ No ☐
17. Have you had periodontal (gum) treatment? ..... Yes ☐ No ☐
18. Have you had orthodontic (braces) treatment? ..... Yes ☐ No ☐
19. Have you ever had treatment by a dental specialist? ..... Yes ☐ No ☐
20. Have you had previous problems with dental treatment? ..... Yes ☐ No ☐
21. Are you satisfied with the appearance of your teeth? ..... Yes ☐ No ☐
22. Are you nervous/anxious/fearful during dental treatment? ..... Yes ☐ No ☐
23. Please list any other information that you feel we should have to provide you with the best possible dental care:

_____

_____ _____

Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

Reviewed By Dentist Date

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PATIENT NAME: _____

MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

1. Do you have any health problems? ..... Yes ☐ No ☐
   If yes, please provide details: _____

2. Has there been any change in your general health or weight in the past year? ..... Yes ☐ No ☐
   If yes, please explain: _____

3. Are you currently being treated for any medical condition or have been treated in the last year? ..... Yes ☐ No ☐
   If yes, please explain: _____

4. When was the last time you had a medical examination? _____
   Were any problems identified? ..... Yes ☐ No ☐
   If yes, please explain: _____

5. Have you ever been hospitalized for any illnesses or operations? ..... Yes ☐ No ☐
   If yes, please provide details: _____

6. Are you taking any medications, non-prescription drugs, homeopathic or herbal supplements, or hormones of any kind? ..... Yes ☐ No ☐
   If yes, please list and provide reason for taking: _____

7. Do you have any allergies or reactions? ..... Yes ☐ No ☐
   If yes, please list using the categories below:
   Medications _____
   Latex/rubber derived products _____
   Other (e.g. seasonal, foods, dyes) _____

8. Have you had an adverse reaction to any dental materials, injections or local anaesthetic? ..... Yes ☐ No ☐
   If yes, please explain: _____

9. Do you have or have you ever had a replacement or a repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ..... Yes ☐ No ☐
   If yes, please explain: _____

10. Have you been advised to take pre-medication (e.g. antibiotics) prior to dental treatment? ..... Yes ☐ No ☐
    If yes, please explain: _____

11. Do you have a prosthetic or artificial joint? ..... Yes ☐ No ☐
    If yes, please provide details: _____

MEDICAL HISTORY CONTINUED ON NEXT PAGE

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MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

12. Do you have any conditions or have undergone therapies that could affect your immune system? ..... Yes ☐ No ☐
(Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)
If yes, please explain: _____

13. Have you ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders? ..... Yes ☐ No ☐
If yes, please explain: _____

14. Do you have a bleeding problem, bleeding disorder, bruising tendency, or have had a blood transfusion? ..... Yes ☐ No ☐
If yes, please explain: _____

15. Do you have any or have you ever had any of the following (check all that apply): ..... Yes ☐ No ☐

- ☐ Fainting/Dizzy spells
- ☐ Eating disorder
- ☐ Stroke/TIA
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Asthma or Emphysema
- ☐ Pacemaker
- ☐ Lung disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Steroid therapy
- ☐ Diabetes
- ☐ Stomach ulcers
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Arthritis/Rheumatism
- ☐ Seizures/Epilepsy
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Hyper/Hypoglycemia
- ☐ Mental or Nervous disorder
- ☐ Circulatory problems
- ☐ Blood transfusion
- ☐ Other communicable disease/ Transmissible infection
- ☐ Chest pain/Angina/Heart attack
- ☐ Drug/Alcohol/Cannabis use or dependency
- ☐ Shortness of breath
- ☐ Osteoporosis

16. Are there any conditions or diseases not listed above that you have or have had? ..... Yes ☐ No ☐
If yes, please explain: _____

17. Are there any diseases or medical problems that run in your family? ..... Yes ☐ No ☐
(e.g. diabetes, cancer, or heart disease)
18. Do you smoke, vape, use e-cigarettes or chew tobacco products? ..... Yes ☐ No ☐
19. Are you pregnant? ..... Yes ☐ No ☐
If yes, what is the expected delivery date: _____
20. Are you breastfeeding? ..... Yes ☐ No ☐

MEDICAL HISTORY CONTINUED ON NEXT PAGE

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MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

21. Do you identify as a person with a disability? ..... Yes ☐ No ☐
    If yes, please explain: _____
22. Have you recently travelled to areas where endemic diseases are present? ..... Yes ☐ No ☐
23. Have you recently experienced any new symptoms such as a cough, fever, chills, vomiting, diarrhea, rash or other illness since recent travel or otherwise? ..... Yes ☐ No ☐
24. Have you had a recent exposure to a communicable infectious disease? ..... Yes ☐ No ☐
    (e.g. measles, chicken pox or tuberculosis)
25. Have you recently received antimicrobial therapy? ..... Yes ☐ No ☐
    If so, for what reason? _____
26. Are your immunizations up to date? ..... Yes ☐ No ☐
27. Is there any additional information related to your health that has not been addressed above? ..... Yes ☐ No ☐
    If so, please advise: _____

_____ _____

Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

_____ _____

Reviewed By Dentist Date