NEW MINAS DENTAL CENTRE

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. Our receptionist is able to assist you with the completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

MR☐ MRS☐ MS☐ MISS☐ DR☐ THIS PATIENT IS AN: ADULT ☐ CHILD ☐

PATIENT NAME (SURNAME, GIVEN): **PREFERRED NAME:**

HOME ADDRESS (NO, STREET, CITY, PROVINCE): POSTAL CODE:

HOME PHONE: OTHER PHONE: EMAIL:

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

BIRTHDATE: SEX: EMPLOYER/SCHOOL: OCCUPATION:

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. ☐

FAMILY PHYSICIAN: PHONE:

IN CASE OF EMERGENCY NOTIFY: RELATION: PHONE:

PERSON RESPONSIBLE FOR THIS ACCOUNT (PLEASE COMPLETE THE INFORMATION BELOW IF DIFFERENT FROM ABOVE):

SELF☐ SPOUSE☐ PARENT☐ LEGAL GUARDIAN☐ OTHER☐

NAME (SURNAME, GIVEN) RELATION:

ADDRESS (NO, STREET, CITY, PROVINCE): PHONE:

INSURANCE INFORMATION (IF YOU HAVE 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:

HOW DID YOU HEAR ABOUT US?

Referred from an existing Patient or Staff (family, friend or colleague), Internet, Community, Professional referral (another health care professional), Emergency/Walk-in or 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☐ DATE

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1. Reason for today's visit: _____
2. Is there a dental problem you would like to take care of as soon as possible? ..... Y ☐ N ☐ O ☐
3. Have you been visiting the dentist regularly? ..... Y ☐ N ☐ O ☐
4. Last dental visit: _____ Last cleaning: _____ Full mouth x-rays: _____
5. How often do you brush your teeth? _____ Floss your teeth? _____
6. Do your gums bleed regularly? ..... Y ☐ N ☐ O ☐
7. Are your teeth sensitive to: ..... Hot ☐ Cold ☐ Biting ☐ Sweets ☐ Sour ☐ N/A ☐
8. Do you feel any pain in your teeth? ..... Y ☐ N ☐ O ☐
9. Do you feel you have bad breath at times? ..... Y ☐ N ☐ O ☐
10. Have you ever had any head, neck or jaw injuries? ..... Y ☐ N ☐ O ☐
11. Have you ever had jaw joint surgery? ..... Y ☐ N ☐ O ☐
12. Do you have pain in your jaw joints or suffer from migraine headaches? ..... Y ☐ N ☐ O ☐
13. Do you have difficulty swallowing? ..... Y ☐ N ☐ O ☐
14. Does any part of your mouth hurt when clenched? ..... Y ☐ N ☐ O ☐
15. Does your jaw crack, click or pop when opened widely? ..... Y ☐ N ☐ O ☐
16. Do you grind or clench your teeth during the day or night? ..... Y ☐ N ☐ O ☐
17. Do you bite your lips/cheeks frequently? ..... Y ☐ N ☐ O ☐
18. Do you smoke or use any other forms of tobacco? ..... Y ☐ N ☐ O ☐
19. Have you ever experienced any growths, lumps or sore spots in your mouth? ..... Y ☐ N ☐ O ☐
20. Have you noticed any loosening/movement of your teeth? ..... Y ☐ N ☐ O ☐
21. Have you had periodontal (gum) treatment? ..... Y ☐ N ☐ O ☐ If yes, date completed: _____
22. Have you had orthodontic treatment? ..... Y ☐ N ☐ O ☐ If yes, date completed: _____
23. Do you wear dentures/partial dentures? ..... Y ☐ N ☐ O ☐ If yes, date of placement: _____
24. Do you have dental implants? ..... Y ☐ N ☐ O ☐ If yes, date of placement: _____
25. Have you ever had treatment by a dental specialist? ..... Y ☐ N ☐ O ☐ If yes, please specify: _____
26. Previous problems with dental treatment? ..... Y ☐ N ☐ O ☐
27. Are you satisfied with the appearance of your teeth? ..... Y ☐ N ☐ O ☐
28. Are you nervous during dental treatment? ..... Y ☐ N ☐ O ☐
29. Please list any other information that you feel we should have to provide you with the best possible dental care:

_____

_____

(Signature) PATIENT☐ PARENT☐ GUARDIAN☐ DATE

_____

(Reviewed By Dentist): DATE

NEW MINAS DENTAL CENTRE

NEW PATIENT FORM

MEDICAL HISTORY (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

1. Are you in good health? ..... Y ☐ N ☐ O ☐
   If no, please provide details:

   _____

2. Has there been any change in your general health or weight in the past year? ..... Y ☐ N ☐ O ☐
   If yes, please explain:

   _____

3. Are you currently being treated for any medical condition or have you been treated in the last year? .... Y ☐ N ☐ O ☐
   If yes, please explain:

   _____

4. When was the last time you had a medical examination? _____
   Were any problems identified? ..... Y ☐ N ☐ O ☐
   If yes, please explain:

   _____

5. Have you ever been hospitalized for any illnesses or operations? ..... Y ☐ N ☐ O ☐
   If yes, please provide details:

   _____

6. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ..... Y ☐ N ☐ O ☐
   If yes, please list and provide reason for taking:

   _____

7. Do you have any allergies? ..... Y ☐ N ☐ O ☐
   If yes, please list using the categories below:

   Medications _____

   Latex/rubber products _____

   Other (e.g. hay fever, foods) _____

8. Have you had a peculiar or adverse reaction to any medicines, injections or dental local anaesthetic? .. Y ☐ N ☐ O ☐
   If yes, please explain:

   _____

9. Have you experienced any new symptoms such as a cough or illness since recent travel or otherwise? . Y ☐ N ☐ O ☐

   _____

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MEDICAL HISTORY (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

10. Have you experienced difficulties walking or going up stairs, such as pain or shortness of breath? Y ☐ N ☐ O ☐

11. 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? Y ☐ N ☐ O ☐

12. Have you ever been advised to take antibiotic pre-medication prior to dental treatment? ..... Y ☐ N ☐ O ☐

13. Do you have a prosthetic or artificial joint? ..... Y ☐ N ☐ O ☐

14. Do you have any conditions or are undergoing any therapies that could affect your immune system? (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy) ..... Y ☐ N ☐ O ☐

15. Have you ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders? ..... Y ☐ N ☐ O ☐

16. Do you have a bleeding problem, bleeding disorder or bruising tendency? ..... Y ☐ N ☐ O ☐

17. Do you have any or have you ever had any of the following (circle all that apply):

a.	Chest pain, angina	i.	Lung disease	q.	Seizures / Epilepsy	y.	Eating disorder
b.	Heart attack	j.	Tuberculosis	r.	Kidney disease	z.	Fainting / Dizzy spells
c.	Stroke	k.	Cancer	s.	Thyroid disease	aa.	High / Low blood pressure
d.	Rheumatic fever	l.	Steroid therapy	t.	Drug / Alcohol dependency	bb.	Hyper / Hypoglycemia
e.	Mitral valve prolapse	m.	Diabetes	u.	Osteoporosis medications	cc.	Mental or Nervous disorder
f.	Heart problems, murmur	n.	Stomach ulcers	v.	Psychiatric disorder / Treatment	dd.	Other communicable
g.	Asthma or Emphysema	o.	High blood pressure	w.	Circulatory problems		disease / Transmissible infection
h.	Pacemaker	p.	Arthritis / Rheumatism	x.	Blood transfusion		

18. Are there any conditions or diseases not listed above that you have or have had? ..... Y ☐ N ☐ O ☐
If yes, please provide details:

_____

19. For women only: are you breastfeeding or pregnant (or think you might be pregnant?)
If pregnant, what is the expected delivery date? _____

20. Is there any additional information related to your health that has not been addressed above?

_____

_____

(Signature) PATIENT☐ PARENT☐ GUARDIAN☐ DATE

_____

(Reviewed By Dentist): DATE

NEW MINAS DENTAL CENTRE

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MEDICAL HISTORY CONTINUED (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

21. Have you developed a fever or chills in the last 24 hours? ..... Y ☐ N ☐ O ☐

22. Have you had a recent and sudden onset of diarrhea? ..... Y ☐ N ☐ O ☐

23. Have you experienced a new undiagnosed rash, lesion or break in your skin? ..... Y ☐ N ☐ O ☐

24. Have you had a recent exposure to communicable infectious disease?
(E.g. measles, chicken pox or tuberculosis?) ..... Y ☐ N ☐ O ☐

25. Have you recently received antimicrobial therapy? ..... Y ☐ N ☐ O ☐
If so, for what reason?

_____

26. Do you have a family history of Prion Disease, or symptoms that may be indicative of
Creutzfeldt-Jakob disease (CJD), such as sudden onset of dementia? ..... Y ☐ N ☐ O ☐

27. Have you recently travelled to areas where endemic diseases are present? ..... Y ☐ N ☐ O ☐

28. Are your immunizations up to date? ..... Y ☐ N ☐ O ☐

29. Are you taking any medications for immunosuppression? ..... Y ☐ N ☐ O ☐

30. Is there any additional information related to your health that has not been addressed above?
If so, please advise:

_____

_____

(Signature) PATIENT☐ PARENT☐ GUARDIAN☐ DATE

_____

(Reviewed By Dentist): DATE