

# New Patient Information

Date \_\_\_\_\_ (D/M/Y)

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care.

**ALL INFORMATION IS STRICTLY CONFIDENTIAL.**

PLEASE PRINT:

Name: \_\_\_\_\_ Dr. Mr. Mrs. Ms. Miss

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_ - \_\_\_\_ cell ( ) \_\_\_\_ - \_\_\_\_ Bus. Phone ( ) \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_ email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (M/D/Y) Sex \_\_\_\_\_ Name of Spouse \_\_\_\_\_

Parent/Guardian names (if patient is a minor) \_\_\_\_\_

Address of Guardian (if different than above) \_\_\_\_\_

In case of emergency, please contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**MEDICAL HISTORY** Family Physician: \_\_\_\_\_ Clinic location \_\_\_\_\_

Answer each question below as best you can. Provide additional information on separate sheets if required.

1. Have you been treated for any medical conditions or had any surgical procedures within the last five years? **Yes No**

Describe \_\_\_\_\_  Y  N

2. Are you presently taking any PRESCRIPTION or NON-PRESCRIPTION medications of any kind?

Please list: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_  Y  N

Have you had any adverse reaction to any of the following medications: (Please Circle?)

**Antibiotics** – Penicillin, Clindamycin, Erythromycin, Metronidazol, Other \_\_\_\_\_  Y  N

**Pain Killers** – Aspirin, Acetaminophen, Codeine, Ibuprophen, Other \_\_\_\_\_  Y  N

Barbiturates (sleeping pills), Iodine, Local Anaesthetics, Nitrous Oxide, Other \_\_\_\_\_  Y  N

4. Do you have instructions from a physician to take pre-medication prior to dental work? \_\_\_\_\_  Y  N

5. Please **shade** in  **yes** or  **no** to INDICATE which of the following conditions you have **ever had** in your medical history:

AIDS/ HIV	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic/Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis/ Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Latex Allergy	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Troubles	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Leukemia/Lymphoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Joints (hip, knee)	<input type="checkbox"/> Y <input type="checkbox"/> N	Glandular Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma/ Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	HBP/LBP	<input type="checkbox"/> Y <input type="checkbox"/> N	Lung Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Auto-Immune Diseases	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur/ Arrhythmia	<input type="checkbox"/> Y <input type="checkbox"/> N	Malignant Hyperthermia	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer /Tumors	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis A/B/C/D/E	<input type="checkbox"/> Y <input type="checkbox"/> N	Mental/Nervous Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Chronic Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N	High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Organ Transplant	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N
Cortisone/Steroid therapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Radiation/Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Condition	<input type="checkbox"/> Y <input type="checkbox"/> N
C-PAP Machine	<input type="checkbox"/> Y <input type="checkbox"/> N	Other- _____					

6. **WOMEN ONLY:** Do you suspect you may be pregnant? Due Date \_\_\_\_\_

# DENTAL HISTORY...we would like to get to know you better.

1. Approximately how long ago was your last dental visit? \_\_\_\_\_ What did you have done? \_\_\_\_\_

2. Reason for leaving your last dentist. \_\_\_\_\_

3. What prompted you to seek dental care at this time? \_\_\_\_\_ **Yes No**

4. Are any of your teeth sensitive? Which areas? \_\_\_\_\_ **Y N**

Please circle: Sensitive to: (a)Hot (b) Cold (c) Sweet (d)Bite Pressure (e) Other \_\_\_\_\_

5. Do you ever avoid any part of your mouth while eating or brushing? Which areas? \_\_\_\_\_ **Y N**

6. Does food constantly get stuck between certain teeth in your mouth? Which areas? \_\_\_\_\_ **Y N**

7. Do you get frustrated because you always have something to be repaired at the dentist? \_\_\_\_\_ **Y N**

8. Are you dissatisfied with the appearance of your teeth? Color, shape, spaces etc. Explain \_\_\_\_\_ **Y N**

9. Are you dissatisfied with the function of your teeth in any way? Explain \_\_\_\_\_ **Y N**

10. Do your gums bleed when you brush or Floss? Which areas? \_\_\_\_\_ **Y N**

11. Do you want to learn how to control / prevent dental disease to achieve **optimal oral health**? \_\_\_\_\_ **Y N**

12. Do you feel that you have constant bad breath or a bad taste in your mouth? \_\_\_\_\_ **Y N**

13. Do you snore?   If yes...are you aware about sleep apnea and how it affects your health? \_\_\_\_\_ **Y N**

14. Have you ever had a bad reaction to dental freezing? (Describe) \_\_\_\_\_ **Y N**

15. Have you had a bad experience in a dental office? (Describe) \_\_\_\_\_

16. Has fear and/or discomfort kept you from regular dental visits? \_\_\_\_\_ **Y N**

17. Would you like sedation for any dental visits? \_\_\_\_\_ **Y N**

18. Do you have concerns about dental care? Please circle: (a) Fear (b) Nervous (c) Time (d) Cost (e) Pain \_\_\_\_\_ **Y N**

Describe \_\_\_\_\_

19. When would you like us to initiate treatment? Please circle:

(a) When it hurts/ breaks (b) When things are worsening (c) When something is not ideal

**GENERAL RELEASE / INFORMED CONSENT** I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history. I have not knowingly omitted any information. **Should there be any changes in my health status, in the future I will inform this dental office.** I understand that the use of medication and anaesthetic agents embodies a certain risk and that consultation with other health care providers may be required prior to treatment. Therefore, I consent to the release of this medical information as deemed necessary for consultation purposes only.

I understand that **it is required that I give at least 48 hours notice** if I have to reschedule an appointment. If I fail to give sufficient notice I understand I will be **charged \$50.00** and will be required to place a deposit in order to schedule another appointment. I understand that responsibility for payment of services is mine and that payment in full is due and payable at the time treatment is rendered.

Please sign: **X** \_\_\_\_\_

**X** \_\_\_\_\_

Patient /guardian

Dr. Karstan Lachman