Welcome to

NAVAN DENTAL CLINIC

Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Adult ☐ Child ☐

Family Name: _____ First Name: _____ Prefers to be called: _____

Address: _____ City: _____ Prov.: ___ Postal Code: _____

Home Phone (____)_____ W (___)_____ Cell (____) _____

Employer/School: _____ Occupation_____

Email: _____

Whom may we thank for referring you?_____

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

Date of birth: _____

Official Language: E ☐ F ☐

Preferred language: _____

Family Physician: _____ Phone # (_____) _____

Emergency Contact:_____ Relation: _____

Phone# (____)-_____

Person responsible for this account: Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ☐

Name: _____ Relation: _____

Home Phone (____) -_____ Work (____) -_____ Cell (____) -_____

Method of payment: cash ☐ cheque ☐ credit card ☐ #_____exp._____

Medical Alert:

| Primary Insurance | Secondary Insurance |
|---|---|
| Subscriber: _____ | Subscriber: _____ |
| Relation: Self ☐ Spouse ☐ Other _____ | Relation: Self ☐ Spouse ☐ Other _____ |
| Insurance Co._____ | Insurance Co_____ |
| Policy/Plan# _____ Division#_____ | Policy/Plan# _____Division#_____ |
| Subscriber I.D or SIN# _____ | Subscriber I.D or SIN# _____ |

## Medical History Please check **YES** or **NO** for Each Question

The following information is required by the Dentist to assist in proper diagnosis and treatment:

| | YES | NO |
|---|---|---|
| **1.** Have you ever had a serious illness requiring hospitalization or extensive medical care? Please specify: _____ | ☐ | ☐ |
| **2.** Are you presently under the care of a physician? If so, please explain: _____ | ☐ | ☐ |
| **3.** Have you had a medical examination in the past year? | ☐ | ☐ |
| **4.** Do you use any prescription or non prescription drugs regularly? Please specify: _____ | ☐ | ☐ |
| **5.** Do you have any allergic conditions e.g. Hay fever, skin rash, food allergies, metal, latex? Please specify: _____ | ☐ | ☐ |
| **6.** Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? Please specify: _____ | ☐ | ☐ |
| **7.** Have you been hospitalized in the last 5 years? Please specify: _____ | ☐ | ☐ |
| **8.** Have you ever experienced any unusual reaction of any of the following? (please circle) Local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills) or any other medicine? If so, please explain _____ | ☐ | ☐ |
| **9.** Have you been warned against taking any drug or medication? | ☐ | ☐ |
| **10.** Do you bruise easily or bleed abnormally? | ☐ | ☐ |
| **11.** Have you had any organ or medical implants? | ☐ | ☐ |
| **12.** Have you ever fainted? | ☐ | ☐ |
| **13.** Do your ankles, feet or hands swell? | ☐ | ☐ |
| **14.** Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? | ☐ | ☐ |
| **15.** Do you experience frequent headaches? | ☐ | ☐ |
| **16.** Do you have A.I.D.S or have tested positive for H.I.V.? | ☐ | ☐ |
| **17.** Have you had any injury, surgery, or x-ray therapy to your face or jaw? | ☐ | ☐ |
| **18. WOMEN ONLY:** Are you pregnant or suspect you might be? If so, what month are you in? | ☐ | ☐ |
| Are you taking birth control pills? | ☐ | ☐ |

## Do you have or have ever had any of the following?

| | | |
|---|---|---|
| ☐ Heart murmur or heart attack | ☐ Malignant hyperthermia | ☐ Liver Disease |
| ☐ Stomach/ Intestinal problems | ☐ Drug/Alcohol Dependency | ☐ Mitral valve prolapse |
| ☐ Joint replacement | ☐ Venereal Disease | ☐ Cold sores |
| ☐ Mental or nervous disorder | ☐ Lung Disease (e.g. asthma) | ☐ Jaundice |
| ☐ High/low blood pressure | ☐ Thyroid Disease | ☐ Diabetes |
| ☐ Hyper (hypo) Glycemia | ☐ Arthritis or Rheumatism | ☐ Tuberculosis |
| ☐ Epilepsy or seizures | ☐ Scarlet or Rheumatic fever | ☐ Hepatitis A,B,C |
| ☐ Cortisone/steroid therapy | ☐ Cancer/Chemotherapy | ☐ Herpes |
| ☐ Sinus Trouble | ☐ Stroke | ☐ Kidney problems |
| ☐ Emphysema | ☐ Glaucoma | ☐ Other: _____ |

## Dental History Please Check **YES** or **NO** for Each Question

| | YES | NO |
|---|---|---|
| **1.** Reason for today's visit ☐Exam ☐Cleaning ☐Emergency ☐Other_____ | | |
| Are you presently having any dental pain? | ☐ | ☐ |
| Is there a dental problem that you would like to take care of as soon as possible | ☐ | ☐ |
| **2.** How frequently do you usually see your dentist? ☐6 months ☐Yearly ☐ Other_____ | | |
| Previous dentist? _____ Last dental visit?_____ | | |
| Last cleaning? _____Full mouth series of x-rays?_____ | | |
| **3.** How often do you brush your teeth? _____ Floss? _____ | | |
| **4.** Do you think you have bad breath? | ☐ | ☐ |
| **5.** Do your gums bleed easily? | ☐ | ☐ |
| **6.** Are your teeth sensitive to: ☐Hot ☐ Cold ☐ Biting ☐ Sweets? | ☐ | ☐ |
| **7.** Do you smoke or use any other forms of tobacco? | ☐ | ☐ |
| **8.** Have you ever had jaw/joint surgery? | ☐ | ☐ |
| **9.** Do you have pain in your jaw joints or suffer from migraine headaches? | ☐ | ☐ |
| **10.** Does any part of your mouth hurt when your teeth are clenched? | ☐ | ☐ |
| **11.** Does your jaw crack or pop when opened widely? | ☐ | ☐ |
| **12.** Have you had: ☐ Braces ☐ Oral surgery ☐ Gum Treatment ☐ Root canal? | ☐ | ☐ |
| **13.** Do you clench or grind your teeth during the day or night? | ☐ | ☐ |
| **14.** Have you ever experienced growths or sore spots in your mouth, if so, where? _____ | ☐ | ☐ |
| **15.** Have you experienced previous problems with any prior dental treatments? | ☐ | ☐ |
| **15**. Are you satisfied with the appearance of your teeth? | ☐ | ☐ |
| **16.** Do you have any other dental concerns or questions?_____ | ☐ | ☐ |

**Office policy:** Your appointment time is reserved especially for you. If you are unable to keep the appointment we will require **48 hours** notice, to prevent cancellation fees.

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to preform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine and I will assume full responsibility for fees associated with these services.

_____ _____

(Signature)☐ Patient ☐Parent ☐ Guardian Reviewing dentist

_____ _____

Please print name Date