ALDERWOOD DENTAL

PATIENT INFORMATION

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set and monitored by our office.

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Child☐ Dr.☐

Surname: _____ Given Name: _____ Sex: ___ Date of Birth: (M/D/Y): _____

Address: _____ Unit: _____ City: _____ Postal Code: _____ Marital Status: ___

Home Phone:(____) _____ Cell Phone: (____) _____ Work Phone (____) _____ Ext: ____

Email: _____ Preferred Contacts? Home☐ Cell☐ Work☐ E-mail☐

Employer/School: _____ Occupation: _____

Person to contact in case of emergency (Relationship) _____ Phone: _____

Family Doctor: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Whom may we thank for referring you? _____

Primary Insurance (M/D/Y)	**Secondary Insurance** (M/D/Y)
Subscriber: _____ Date of Birth: _____	Subscriber: _____ Date of Birth: _____
Relationship: Self ☐ Spouse ☐ Other: _____	Relationship: Self ☐ Spouse ☐ Other: _____
Employer: _____	Employer: _____
Insurance: _____	Insurance: _____
Policy/Plan #: _____ Div: _____	Policy/Plan #: _____ Div: _____
Certificate/IDN _____	Certificate/IDN _____
Method of Payment: Cash ☐ Debit ☐ Credit Card ☐	

MEDICAL QUESTIONNAIRE

	YES	NO
1. Have you had a medical check-up in the last year? _____	☐	☐
2. Have you ever been hospitalized or had major operations? If so, please explain: _____	☐	☐
3. Are you presently under the care of a physician? If so, please explain: _____	☐	☐
4. Do you have any allergies?	☐	☐
Medications (penicillin, aspirin, codeine, sulpha drugs, local anesthetic, etc) _____		
Latex/rubber products _____		
Other (hay fever, foods/colouring) _____		
5. Have you ever had an unusual reaction to any medications or injections? If so, please explain: _____	☐	☐
6. Are you taking any **medications**, non-prescription drugs, recreational drugs, or herbal supplements: _____	☐	☐
If so, please explain: _____		
7. Do you suffer from a mental/nervous disorder? If so, explain: _____	☐	☐
8. Do you smoke, vape or chew tobacco products? _____	☐	☐
9. Do you require **pre-medication** for dental treatment? _____	☐	☐
10.Have you ever had any organ implant or medical implants? (i.e. valves, stents, joints) _____	☐	☐
11.Do you experience shortness of breath or chest pains when taking a walk or climbing stairs? _____	☐	☐
12.Have you had any injury, surgery or x-ray therapy to your face or jaws? _____	☐	☐
13.For Women Only:		
Are you pregnant or suspect you might be? If so, what month are you in? _____	☐	☐
Are you taking birth control pills? _____	☐	☐
Are you nursing? _____	☐	☐

YES NO

14.Do you have or have ever had any of the following: Please check any that apply _____ ☐ ☐

□Anaphylaxis	□Diabetes 1 or 2	□Malignant Hyperthermia	□Glaucoma
□Joint Replacement	□High/Low Blood Pressure	□AIDS/HIV Positive	□Sleep Apnea
□Mitral Valve Prolapse	□Hyper/Hypo Glycemia	□Hepatitis A,B,C	□Hearing Problems
□Heart Murmur	□High/Low Cholesterol	□Arthritis or Rheumatism	□Liver Disease
□Heart Attack	□Hyper/Hypo Thyroid	□Scarlet/Rheumatic Fever	□Stomach Problems
□Heart Pacemaker	□Osteoporosis	□Sinus Troubles	□Kidney Problems
□Irregular heart beat	□Blood Disorder	□Drug/Alcohol Addiction	□Autistic Spectrum
□Heart Disease	□Blood transfusion	□Alzheimer's Disease	□Sickle Cell Disease
□Angina	□Excessive Bleeding	□Parkinson's Disease	□Celiac Disease
□Stroke	□Bruise easily	□Leukemia	□Crohn's Disease
□Asthma/Bronchitis	□Fainting Spells	□Cancer	□Cold Sores
□Lung Disease	□Steroid Therapy	□Chemotherapy/radiation	□Headaches
□Emphysema	□Lupus	□Epilepsy	□Tuberculosis

15.Do you or have you ever had any other serious illness not listed above? If so, please explain: _____ ☐ ☐

_____

DENTAL QUESTIONNAIRE

1. What is your main priority in seeking dental treatment?_____
2. How frequently do you see your dentist? □4months □6 months □9months □Yearly □Other_____
   Last dental visit: _____Last cleaning: _____Date of most recent x-rays? _____
3. How often do you brush your teeth? _____ Floss? _____
4. Do your gums bleed easily? _____ ☐ ☐
5. Are your teeth sensitive to: □Hot □Cold □Biting □Sweet? _____ ☐ ☐
6. Have you ever had jaw joint surgery? _____ ☐ ☐
7. Does your jaw crack or pop when opened widely? _____ ☐ ☐
8. Do you grind or clench your teeth during the day or night? _____ ☐ ☐
9. Have you had: □Orthodontics □Oral Surgery □Gum treatment □Root canal □Implant □Denture □ Nightguard _____ ☐ ☐
10.Have you had any negative experiences with dentistry? _____ ☐ ☐
11.Have you ever had trouble getting numb/frozen? _____ ☐ ☐
12.Are you happy with the appearance of your smile? If not, what would you like to see changed? ☐ ☐
   (straighter teeth, whiter teeth, etc.) _____
13. Other Dental Concerns: _____

Release of Information: I authorize Alderwood Dental to release and/or obtain information and/or radiographs, when required, regarding my medical/dental history from my physician, another dental office, insurance company.
Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment we will require 24 hour notice, otherwise it may be necessary to charge for the time lost.
Patient Release: I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

SIGNATURE _____ DATE: (M/D/Y) _____

□Patient □Parent □Guardian

DOCTOR'S SIGNATURE _____