Dentistry in Streetsville

WHERE DENTISTRY BECOMES art

Welcome to our office. We sincerely appreciate you choosing our office for your dental health care needs. Please be assured we will work hard to continually earn the trust you have placed in us. Your cooperation in filling out this questionnaire is essential to providing you with the highest standard of dental care. **All information is strictly confidential** and will remain in this office as per the Privacy Act Standards set up and monitored by our office. Our receptionist is available to assist you in completing this form. **PLEASE PRINT.**

**MEDICAL ALERT**

Today's Date: ____ / ____ / ____ (M / D / Y)

Name: Dr.❑ Mr.❑ Mrs.❑ Miss❑ Ms.❑ (Last / First / Initial)

Date of Birth: ____ / ____ / ____ (M / D / Y)

Marital Status: ____

Address: ____ (Street / City / Prov. / Postal Code)

Home Tel.: ____

Work Tel: ____ Ext ____ Cell No.: ____ Preferred contact method ____

E-mail: ____

❑ I give express consent to receive commercial electronic messages, including appointment reminders. I can unsubscribe at any time.

Family Physician: ____ Tel: ____

Person Responsible for Account: Self❑ Parent❑ Spouse❑ Other❑ Name: ____ Tel: ____ Ext. ____

Address: ____

Your Occupation: ____ Employed by: ____ Tel: ____ Ext. ____

Spouse's Occupation: ____ Employed by: ____ Tel: ____ Ext. ____

If a Child (Parent or Guardian's Name): ____ Address (If Different): ____

In Case of Emergency Notify: ____ Relationship: ____ Tel: ____ Ext. ____

Names of other family members who are patients at our office: ____

How did you hear about us? ____

Are you available on short notice? ____ Children Only: School ____ Grade ____

| PRIMARY DENTAL INSURANCE Y❑ N❑ | | | SECONDARY DENTAL INSURANCE Y❑ N❑ | | |
|---|---|---|---|---|---|
| NAME OF INSURED/SUBSCRIBER | | DATE OF BIRTH | NAME OF INSURED/SUBSCRIBER | | DATE OF BIRTH |
| INSURANCE CARRIER | | TEL: | INSURANCE CARRIER | | TEL: |
| GROUP/POLICY NUMBER | CERT. # | DIVISION/SECT # | GROUP/POLICY NUMBER | CERT. # | DIVISION/SECT # |

Are you familiar with your plan details? Yes❑ No❑ If not, please ask us if you have any concerns.

## MEDICAL HISTORY

Please check the appropriate box: Yes - Y Maybe/Not sure-? No - N

| | Y | ? | N |
|---|---|---|---|
| 1) Are you presently under the care of a physician for any medical condition? If yes please specify: ____ Physicians' Name: ____ Tel: ____ | | | |
| 2) Are you taking or have you recently taken **any** prescription or non-prescription drugs. Specify: A) Drug ____ Reason ____ B) Drug ____ Reason ____ | | | |
| 3) Do you or have you ever had any heart or blood pressure problems (e.g. heart attack, heart murmur, mitral valve prolapse, angina, heart pacemaker, heart rhythm disorder, rheumatic fever, high or low blood pressure)? | | | |
| 4) Do you experience shortness of breath or chest pains when taking a walk or climbing stairs? | | | |
| 5) Have you ever been hospitalized for any serious illnesses or operations? Explain: | | | |
| 6) Have you ever had treatment for a tumor or growth (e.g. radiation, surgery, chemotherapy)? | | | |
| 7) Have you gained or lost excessive weight recently? | | | |
| 8) Have you ever taken appetite suppressants? | | | |
| 9) Time since your last medical check-up? ____ Time since your last visit to a physician? ____ Reason for visit: | | | |
| 10) Have you ever experienced an allergic or other bad reaction to a medication, injection, material or food of any kind (e.g. penicillin, aspirin, general anesthetics, freezing, codeine, metals, latex, sedatives). | | | |
| 11) Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut? | | | |
| 12) Do you have any conditions that could affect your immune system (e.g. AIDS, HIV positive, leukemia. etc)? | | | |
| 13) Do you have or have you ever had jaundice, hepatitis (A, B or C), or liver disease? | | | |
| 14) Do you smoke, vape, chew tobacco, or use cannabis/a transdermal nicotine patch? How much? ____ | | | |
| 15) **For women only:** Are you pregnant or suspect you might be? If so what is the expected delivery date? ____ Are you taking birth control pills? | | | |

**PLEASE COMPLETE BOTH SIDES**

## MEDICAL HISTORY (con't)

| | Y | ? | N |
|---|---|---|---|
| 16) Do you have or have you recently had any of the following? ❑ Mumps ❑ Chicken Pox ❑ Measles ❑ Strep Throat ❑ Tonsilitis | | | |
| 17) Do you have frequent earaches, ear/throat infections or any hearing difficulties? | | | |
| 18) Do you have or have you ever had any blood disorders (e.g. anemia, sickle cell disease, hemophilia, iron deficiency, etc)? | | | |
| 19) Do you or does any member of your family have diabetes? | | | |

20) Do you have or have you ever had any of the following? Please check off any that apply.

| | | | | | |
|---|---|---|---|---|---|
| ❑ Chest Pain/Angina | ❑ Bronchitis/Asthma | ❑ Tuberculosis | ❑ Stomach Ulcers | ❑ Sinus Trouble | ❑ Hyper (Hypo) glycemia |
| ❑ Thyroid disease | ❑ Stroke | ❑ Cancer | ❑ Glaucoma | ❑ Lung Disease | ❑ Rheumatic/Scarlet Fever |
| ❑ Organ Transplants | ❑ Prosthetic Implant/Joint | ❑ Liver Disease | ❑ Alcohol/Drug Dependency | | ❑ Emphysema |
| ❑ Epilepsy or Seizures | ❑ Fainting or Dizzy Spells | ❑ Kidney Disease | ❑ Arthritis/Rheumatism | | ❑ Intestinal Problems |
| ❑ Circulation Problems | ❑ Venereal Disease/Herpes | ❑ Mental/Nervous Disorder or Psychiatric Treatment | | | ❑ Osteoporosis |
| ❑ Artificial Heartvalve | ❑ Cortisone/Steroid therapy | ❑ Malignant Hyperthermia | | | |

❑ Other: Please Specify _____ ❑ None of the Above

21) Is there anything the doctor should know about your medical history that has not been mentioned? Please specify:

To the best of my knowledge, the above information is correct. I understand that omitting information now or in the future can cause complications to my treatment.

Reviewed by Treating Dentist

X _____ (Patient's Signature) _____ Date

X _____ (Signature of Treating Dentist) _____ Date

## DENTAL HISTORY

| | Y | ? | N |
|---|---|---|---|
| 1) How long since your last visit to the dentist? ___Yrs. ___Mths. Date of last dental cleaning _____ Did you receive dental x-rays at the time? | | | |
| 2) Have you ever been in a vehicle accident or experienced any blows to your jaws? | | | |
| 3) Have you ever had implant surgery in one or both of your jaw joints? If you answered yes, who performed the surgery and when was it done? | | | |
| 4) Do you frequently get cold sores? | | | |
| 5) Are you unsatisfied with the appearance of your teeth? If so, please specify: ❑ Crowding ❑ Gaps ❑ Size ❑ Colour ❑ Shape ❑ Chips ❑ Other_____ | | | |
| 6) Have you ever had any of the following dental treatments (please check): ❑ Extraction ❑ Implants ❑ Crowns or Caps ❑ Bridgework ❑ Orthodontics ❑ Root Canal ❑ Gum Surgery ❑ Full or Partial Dentures | | | |

Reason for today's visit Exam ❑ Cleaning ❑ Emerg ❑ Other _____

| | Y | ? | N |
|---|---|---|---|
| 7) Are you presently having dental pain? | | | |
| 8) Are you interested in sedation/gas during your treatment? | | | |
| 9) Do your gums bleed when: ❑ Brushing? ❑ Flossing? | | | |
| 10) Do your gums feel swollen or tender? | | | |
| 11) Do you feel that you have bad breath? | | | |
| 12) Do you grind or clench your teeth? | | | |
| 13) Does food routinely catch between your teeth? | | | |
| 14) Have you ever had any problem with previous dental work? | | | |
| 15) Are your teeth sensitive to: ❑ Cold ❑ Hot ❑ Sweets ❑ Biting ❑ Other? Specify: | | | |
| 16) Do you snore when you are asleep? | | | |
| 17) Do you wake up with a headache or having a tired feeling in your face and jaws? | | | |

Describe in your own words what you would like done with your teeth.

**Privacy Act Notification:** I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.

**Office Policy:** Your appointment is reserved especially for you. If you are unable to keep the appointment we require 48 hours notice, otherwise there may be at least a $100.00 charge for the time lost. Office policy is that services are paid for as they are performed. However, in certain circumstances, arrangements for payment may be made by consulting the doctor. Outstanding balances are subject to interest and late payment charges and /or collection costs.

**Patient Release:** I understand that the nature of any necessary recommended treatment will be discussed and approved by me prior to commencement. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist/staff to perform diagnostic procedures as may be necessary for proper dental care. I also understand the consultation with my medical doctor may be required, and I consent to my physician being contacted, if necessary. 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. I authorize Dr. Cyril Tahtadjian to submit electronic/manual claims/predeterminations to above mentioned insurance carriers on my behalf.

PARENT/GUARDIAN TO SIGN IF PATIENT UNDER 16

Date ___/___/___ (M/D/Y) X _____ (Signature) ❑ PATIENT ❑ PARENT ❑ GUARDIAN PRINT NAME OF GUARDIAN _____

**NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.**