

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**

Name: Dr.  Mr.  Mrs.  Miss  Ms.

Last First Initial

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M D Y

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: Name: \_\_\_\_\_ Tel: \_\_\_\_\_ Ext. \_\_\_\_\_  
 Self  Parent  Spouse  Other  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			SECONDARY DENTAL INSURANCE				
		Y <input type="checkbox"/>	N <input type="checkbox"/>			Y <input type="checkbox"/>	N <input type="checkbox"/>
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
1) Are you presently under the care of a physician for any medical condition? If yes please specify: _____ Physicians' Name: _____ Tel: _____	Y	?	N	9) Time since your last medical check-up? _____ Time since your last visit to a physician? _____ Reason for visit: _____
2) Are you taking or have you recently taken <b>any</b> prescription or non-prescription drugs. Specify: A) Drug _____ Reason _____ B) Drug _____ Reason _____	Y	?	N	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).
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)?	Y	?	N	11) Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut?
4) Do you experience shortness of breath or chest pains when taking a walk or climbing stairs?	Y	?	N	12) Do you have any conditions that could affect your immune system (e.g. AIDS, HIV positive, leukemia. etc)?
5) Have you ever been hospitalized for any serious illnesses or operations? Explain: _____	Y	?	N	13) Do you have or have you ever had jaundice, hepatitis (A, B or C), or liver disease?
6) Have you ever had treatment for a tumor or growth (e.g. radiation, surgery, chemotherapy)?	Y	?	N	14) Do you smoke, chew tobacco, or use a transdermal nicotine patch? How much? _____
7) Have you gained or lost excessive weight recently?	Y	?	N	15) For women only: Are you pregnant or suspect you might be? If so what is the expected delivery date? _____
8) Have you ever taken appetite suppressants?	Y	?	N	Are you taking birth control pills? _____

# MEDICAL HISTORY (con't)

Y	?	N
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Y	?	N
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16) Has the **Child Patient** recently had any of the following:

- Mumps     Chicken Pox  
 Measles     Strep Throat     Tonsillitis

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18) Do you have or have you ever had any blood disorders (e.g. anemia, sickle cell disease, hemophilia, iron deficiency, etc)?

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17) Do you have frequent earaches, ear/throat infections or any hearing difficulties?

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19) Do you or does any member of your family have diabetes?

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

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

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
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Reason for today's visit Exam  Cleaning   
Emerg  Other \_\_\_\_\_

Y	?	N
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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? \_\_\_\_\_

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7) Are you presently having dental pain?

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2) Have you ever been in a vehicle accident or experienced any blows to your jaws?

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8) Are you interested in sedation/gas during your treatment?

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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?

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9) Do your gums bleed when:  Brushing?  
 Flossing?

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4) Do you frequently get cold sores?

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10) Do your gums feel swollen or tender?

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5) Are you unsatisfied with the appearance of your teeth? If so, please specify:  Crowding  Gaps  Size  
 Colour  Shape  Chips  Other \_\_\_\_\_

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11) Do you feel that you have bad breath?

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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

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12) Do you grind or clench your teeth?

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13) Does food routinely catch between your teeth?

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14) Have you ever had any problem with previous dental work?

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15) Are your teeth sensitive to:  Cold  Hot  Sweets  
 Biting  Other? Specify: \_\_\_\_\_

16) Do you snore when you are asleep?

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17) Do you wake up with a headache or having a tired feeling in your face and jaws?

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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 \$50.00 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 claims to above mentioned insurance carriers on my behalf.

PARENT/GUARDIAN TO SIGN  
IF PATIENT UNDER 16

Date \_\_\_ / \_\_\_ / \_\_\_ 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.**