GET ACQUAINTED QUESTIONNAIRE - ADULT

Personal Information

Patient's Name: Mr. Mrs. Miss Ms _____

Prefers to be called: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone No: Home (____) _____ - _____ Business: (____) _____ - _____ S.I.N. _____/_____/_____

Date of Birth: M ___ D ___ Y ___ Age: ___ Gender: ___ Marital Status: ___ Name of Spouse: _____

Whom may we thank for referring you? _____ Email Address: _____

In case of emergency, please contact: _____ Phone: (____) _____ - _____

Family Physician: _____ Phone: (____) _____ - _____

Insurance Information

Primary Insurance:

Name of Insured: _____ Date of Birth: M ___ D ___ Y ___ Employer: _____

Insurance Company: _____ Policy Number: _____ Certification Number: _____

Check Up Frequency: □ 6 months □ 9 months □ 12 months □ Other (explain) _____

Secondary Insurance:

Name of Insured: _____ Date of Birth: M ___ D ___ Y ___ Employer: _____

Insurance Company: _____ Policy Number: _____ Certification Number: _____

Check Up Frequency: □ 6 months □ 9 months □ 12 months □ Other (explain) _____

Dental History

Is there a dental problem you would like treated immediately? If yes explain _____

Date of last dental checkup: _____ months/years Are you nervous about seeing a dentist? □ Yes □ No

Have you had a complete dental exam with full x-ray series within the last three years? □ Yes □ No

Are you unhappy with the appearance of your teeth? □ Yes □ No

If yes, what would you like to see changed? _____

Have you ever experienced any of the following jaw problems?

□ clicking/popping in your jaw joints □ Pain in you jaw joints, around your ear, or side of your face

□ Difficulty in opening or closing □ Pain when teeth are clenched □ Pain or difficulty while chewing

Do you have any of the following habits?

□ Clenching or grinding your teeth while awake or asleep □ Biting your cheeks or lips

□ Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? □ Mouth breathing while awake or asleep

Do you have or have you had any of the following? (please check if applicable)

□ Teeth sensitive to: Cold Hot Sweets Pressure □ Orthodontic treatment □ Frequent blisters on lips or mouth

□ Periodontal (gum) treatment □ Loose/Shifted teeth □ Food catching between teeth (impaction)

□ Bleeding gums when brushing/eating/flossing □ Bad breath □ Growths or sore spots in mouth

Have you ever been advised to take antibiotics prior to a dental appointment?

Medical History

Are you being treated for any medical condition at present or within the past two years? □ Yes □ No

If yes, please explain _____

Physician/Specialist: _____ Phone: _____

Have you been hospitalized in the past two years? _____

When was your last visit to a Physician? _____ Last complete Physical? _____

Have you recently, or are you presently, taking any **prescription** or **non-prescription** drugs including herbal remedies?

1. _____ 2._____ 3._____

4. _____ 5._____ 6._____

Have you ever reacted adversely to any medications or injections? ie: Penicillin, or other antibiotics, aspirin, codeine, local anaesthetic (freezing), nitrous oxide, or any other medicine: _____

Have you ever been advised against taking any specific type of medication? _____

Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex allergies, Skin Rashes, Hives or other allergic conditions? _____

Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: _____

Is there a family history of Diabetes, Cancer or Heart Disease? If so, who? _____

Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? □ Yes □ No Do your ankles, hands or feet swell? □ Yes □ No

Has your weight, appetite or energy level changed dramatically recently? If so why? _____

Do you follow a special diet or are you on a diet pill therapy? _____

Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____

Have you tested HIV positive? □ Yes □ No Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? □ Yes □ No

Have you ever had any injury or surgery to your face or jaws? _____

Do you wear eyeglasses or contact lenses? □ Yes □ No Do you have any hearing difficulties? □ Yes □ No

Do you smoke or use any other forms of tobacco? If yes, how many a day? _____

Are you alcohol and/or drug dependent? _____ If so, have you received treatment? _____

Indicate which of the following you presently have or have ever had:

A.I.D.S.	□	Glaucoma	□	Lupus	□
Anemia	□	Head/neck injuries	□	Malignant Hyperthermia	□
Angina pectoris	□	Heart disease or attack	□	Mental/nervous disorders	□
Arthritis/rheumatism	□	Heart murmurs	□	Mitral valve prolapse	□
Artificial heart valve	□	Heart pacemaker	□	Organ transplant/medical implant	□
Artificial joints(knee, hip)	□	Heart rhythm disorder	□	Psychiatric treatment	□
Blood disorders	□	Heart surgery	□	Radiation treatment/chemotherapy	□
Bronchitis	□	Hepatitis A B C _____	□	Scarlet fever → Rheumatic fever	□
Cancer	□	Herpes	□	Sickle cell disease	□
Circulation problems	□	High/Low blood pressure	□	Sinus trouble	□
Congenital heart lesions	□	Hodgkins disease	□	Stomach/intestinal problems/Ulcers	□
Cortisone/steroid	□	Hyper (Hypo) Glycemia	□	Stroke	□
Crohn's disease	□	Hypertension	□	Thyroid disease	□
Diabetes	□	Inflammatory bowel disease	□	Tuberculosis	□
Emphysema	□	Jaundice	□	Venereal disease	□
Epilepsy or seizures	□	Kidney disease	□	Other_____	
Fainting or dizzy spells	□	Liver disease	□	Other_____	
Glandular disorders	□	Lung disease	□	Other_____	

WOMEN ONLY: Are you pregnant or suspect you may be? _____ If yes, expected delivery date _____

Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____

Do you wish to speak privately to the Doctor about any problem or medical condition? _____

GENERAL RELEASE (Please sign after completing medical questionnaire.)

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. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____

(Signature) Patient □ Parent □ Guardian □ (print name of guardian)

Reviewed by Treating Dentist: _____ Date: _____