Carling Heights
DENTAL CLINIC

Date:__________________

Last Name	Mr. Mrs. Dr. Ms.	Given Name	Contact Number
Address			City / Postal Code
Date of Birth mmm/dd/yyyy		Reason for today's visit ◻ Examination ◻ Emergency	
Occupation	Employer		Business Phone
In case of emergency notify		Relationship	Phone
Name of person responsible for your account ◻ Self ◻ other:		Whom may we thank for referring you? Name:	
Do you have dental insurance? ◻ Yes ◻ No	Name of Insured Employee	Insurance Company	Employer
	Group Policy or Plan Number	Certificate or ID Number	
Policy Holder Date of Birth		Pharmacy	
Family Physician	Phone	Previous Dentist	Address or Phone

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

DENTAL HISTORY

1. Reason for today's visit:____
2. Last dental visit:__________________________ Reason for last dental visit:__________________________
3. Are you nervous during dental treatment? ◻ yes ◻ no ◻not sure/maybe
4. How nervous are you? (Indicate by marking the scale below)
   NOT AT ALL – 1 – 2 – 3 – 4 – 5 – VERY ANXIOUS
5. If you are nervous, would you like to consider additional techniques, along with "freezing", to help you?
   ◻ yes ◻ no ◻not sure/maybe
6. Have you ever had any serious trouble with any previous dental treatment, including local anaesthetic?
   ◻ yes ◻ no ◻not sure/maybe
7. Have you ever had any of the followings?
   ◻ fillings ◻ extractions ◻ regular cleanings ◻ root canal treatment ◻ recent dental X-rays
   ◻ Full or partial denture ◻ nitrous oxide (laughing gas) ◻ orthodontics (braces)
   ◻ periodontics (gum treatment) ◻ any injury to your mouth or jaws ◻ caps or crowns
8. Do you presently have or think you may have any of the following:
   ◻ loose teeth ◻ a bad taste in your mouth ◻ cavities ◻ gum disease
   ◻ earaches or headaches ◻ sensitive teeth ◻ bleeding gums ◻ snoring
   ◻ unsightly or broken fillings ◻ dead or abscessed teeth ◻ a clicking or sore jaw

MEDICAL HISTORY

1. Are you being treated for any medical condition at the present or have you been treated within the past year?
   ◻ yes ◻ no ◻ not sure/maybe
2. When was your last medical check-up? ____
3. Has there been any change in your general health in the past year? If yes, please explain.
   ◻ yes ◻ no ◻ not sure/maybe
4. Are you taking any medications or non-prescription drugs or herbal supplements of any kind? If yes, please list.
   ◻ yes ◻ no ◻ not sure/maybe

   ____

5. Do you have any allergies? If you answered yes, please list using the categories below.
□ yes □ no □ not sure/maybe
a) medications:___
b) latex/rubber products:___
c) other (e.g. hayfever, foods):___
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
□ yes □ no □ not sure/maybe
___
7. Do you have or have you ever had asthma? □ yes □ no □ not sure/maybe
8. Do you have or have you ever had any heart or blood pressure problems? □ yes □ no □ not sure/maybe
___
9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
□ yes □ no □ not sure/maybe
___
10. Do you have a prosthetic or artificial joint? □ yes □ no □ not sure/maybe
___
11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? □ yes □ no □not sure/maybe
___
12. Have you ever had hepatitis, jaundice or liver disease? □ yes □ no □not sure/maybe
___
13. Do you have a bleeding problem/disorder or bruise easily? □ yes □ no □not sure/maybe
___
14. Have ever been hospitalized for any illness or operations? If yes, please explain. □ yes □ no □not sure/maybe
___
15. Do you have or have you ever had any of the following? Please check.

□ chest pain	□ rheumatic fever	□ pacemaker	□ steroid therapy	□ seizures(epilepsy)	□ osteoporosis medications (e.g. Fosamax, Actonel)
□ heart attack	□ mitral valve prolapse	□ lung disease	□ diabetes	□ kidney disease	□ blood transfusion
□ stroke	□ heart murmur	□ tuberculosis	□ stomach ulcers	□ thyroid disease	□ other transmissible disease
□ shortness of breath	□ asthma or emphysema	□ cancer	□ arthritis	□ drug/alcohol dependency	
□ psychiatric disorder or treatment	□ circulatory problems	□ hyper/hypo-glycemia	□ eating disorder	□ mental/nervous disorder	
		□ high/low blood pressure	□ fainting/dizzy spells		

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
□ yes □ no □not sure/maybe
___
17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
□ yes □ no □not sure/maybe
___
18. Do you smoke or chew tobacco products? □ yes □ no □not sure/maybe
___
19. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
□ yes □ no □not sure/maybe
___

CONSENT FORM: I ACKNOWLEDGE that the information given above is true to the best of my knowledge and that the questions have been reviewed with me. Should there be any change to my present health status in the future, I will advise Carling Heights Dental Clinic. I have been informed that my physician may be contacted by letter, fax or telephone in order to complete details of my medical history. I hereby consent to my physician providing the Carling Heights Dental Clinic with any information in this regard which may help ensure safe dental treatment. Finally, I hereby acknowledge that dental treatment may be delayed until all medical information required by the dental clinic is received.

Date: ___ Patient/Parent/Guardian Signature: ___

Date: ___ Dentist Signature: ___