

PATIENT INFORMATION

Welcome to Thornhill Family Dentistry

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.

PERSONAL INFORMATION

Dr. Mr. Mrs. Ms. Miss Mstr.

First Name: _____

Preferred Name: _____

Last Name: _____

Date of Birth (DD/MM/YY): _____ / _____ / _____

Home Address: _____

Apt: _____

City: _____

Postal Code: _____

Email: _____

Home Tel: _____

Work Tel: _____

Cell: _____

Employer: _____

Occupation: _____

Physician: _____

Physician's Phone No: _____

Previous Dentist: _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Policy Holder: _____

Secondary Policy Holder: _____

Relation: Self Spouse Other: _____

Relation: Self Spouse Other: _____

Date of Birth of Insured (DD/MM/YY): _____ / _____ / _____

Date of Birth of Insured (DD/MM/YY): _____ / _____ / _____

Insurance Co: _____

Insurance Co: _____

Policy Plan#: _____ Division/Sect#: _____

Policy Plan#: _____ Division/Sect#: _____

Certificate ID#: _____

Certificate ID#: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Tel: _____

MEDICAL HISTORY

YES NO

Are you being treated for any medical condition at the present or have you been treated within the last year? YES NO

If yes, specify: _____

When was your last medical check-up? _____

Has there been any change in your general health in the past year? YES NO

Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? YES NO

If yes, please list them: _____

Do you have any allergies? Latex Metal/Jewelry Other e.g. Hayfever, Foods YES NO

Have you had an unusual reaction to any drugs or medicines? YES NO

Penicillin Sulfonamide Aspirin Codeine Local Anesthetic Other: _____

Have you ever taken cortisone or steroid medication? YES NO

Do you have or have you ever had any heart problems? YES NO

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? YES NO

Do you have or have you ever had jaundice, hepatitis or liver disease? YES NO

Do you have a bleeding problem or bruise easily? YES NO

Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia etc? YES NO

Do you smoke or chew tobacco products? If yes, how much? _____ YES NO

Have you ever been hospitalized for any serious illnesses or operations? YES NO

Do you have any prosthetic or artificial joints? YES NO

Do you have or have you ever had any of the following?

- | | | | | |
|---|--|--|------------------------------------|--|
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy/Radiation |
| <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sinusitis |

YES NO

Are there any conditions or diseases not listed above that you have or have had? YES NO

If yes, please list: _____

For women only: Are you pregnant, breastfeeding, or taking birth control pills? YES NO

DENTAL HISTORY

What are the main reasons for your visit? _____

When was your last dental visit? _____

When did you last have dental x-rays? _____

How often do you: Brush your teeth? _____ Floss your teeth? _____

YES NO

Are any of your teeth sensitive to cold, heat or chewing? YES NO

Do you get food jammed in between your teeth? YES NO

Do your gums bleed when brushing or flossing? YES NO

Have you ever had professional treatment for your gums? YES NO

Are you aware of clenching/grinding your teeth during the day or night? YES NO

Do your jaw joints click, pop, or make grating noises? YES NO

Have you ever been in a vehicle accident or experienced any blows to your jaw? YES NO

Have you ever had any implant surgery in one or both of your jaws or jaw joints? YES NO

If "yes", who performed the surgery and when was it done? _____

Are you being followed up by a dental specialist? YES NO

Do you suffer from headaches? If "yes", approximately how many per month? _____ YES NO

Have you ever had your wisdom teeth removed? YES NO

Have you had orthodontic treatment (braces)? YES NO

If you play sports, do you wear a mouthguard? YES NO

SMILE ANALYSIS

YES NO

Are you pleased with the appearance of your teeth? YES NO

If not, what would you like to improve? _____

Do you have gaps between your teeth that you would like closed? YES NO

Would you like to have your teeth whiter? YES NO

Do you have chipped or broken teeth which you would like to fix? YES NO

Do you have any crooked or misaligned teeth that bother you? YES NO

To the best of my knowledge, the above information is correct.

Signature of Patient (Parent/Guardian)

DD/MM/YYYY

Reviewed by Dentist

DD/MM/YYYY

**Please bring completed form to your appointment*