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

Title:

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: ______________________

Relation: ☐ Self ☐ Spouse Other: ______________________

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

Insurance Co: ______________________

Policy Plan#: ______________ Division/Sect#: ______

Certificate ID#: ______________________

Secondary Policy Holder: ______________________

Relation: ☐ Self ☐ Spouse Other: ______________________

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

Insurance Co: ______________________

Policy Plan#: ______________ Division/Sect#: ______

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?	☐	☐
If yes, specify: ______________________		
When was your last medical check-up? ______________________		
Has there been any change in your general health in the past year?	☐	☐
Are you taking any medications, non-prescription drugs, or herbal supplements of any kind?	☐	☐
If yes, please list them: ______________________		
Do you have any allergies? ☐ Latex ☐ Metal/Jewelry ☐ Other e.g. Hayfever, Foods ______________	☐	☐
Have you had an unusual reaction to any drugs or medicines?	☐	☐
☐ Penicillin ☐ Sulfonamide ☐ Aspirin ☐ Codeine ☐ Local Anesthetic ☐ Other: ______________		
Have you ever taken cortisone or steroid medication?	☐	☐
Do you have or have you ever had any heart problems?	☐	☐
Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?	☐	☐
Do you have or have you ever had jaundice, hepatitis or liver disease?	☐	☐
Do you have a bleeding problem or bruise easily?	☐	☐
Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia etc?	☐	☐
Do you smoke or chew tobacco products? If yes, how much? ______________	☐	☐
Have you ever been hospitalized for any serious illnesses or operations?	☐	☐
Do you have any prosthetic or artificial joints?	☐	☐

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

- ☐ Chest Pain/Angina
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Emphysema
- ☐ Asthma
- ☐ Epilepsy/Seizures
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Chemotherapy/Radiation
- ☐ Psychiatric Disorder
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Stroke
- ☐ Osteoporosis/Osteopenia
- ☐ Stomach Ulcers
- ☐ Diabetes
- ☐ Drug/Alcohol Dependency
- ☐ Pacemaker
- ☐ Sinusitis

	YES	NO
Are there any conditions or diseases not listed above that you have or have had?	☐	☐
If yes, please list:_______________		
For women only: Are you pregnant, breastfeeding, or taking birth control pills?	☐	☐

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?	☐	☐
Do you get food jammed in between your teeth?	☐	☐
Do your gums bleed when brushing or flossing?	☐	☐
Have you ever had professional treatment for your gums?	☐	☐
Are you aware of clenching/grinding your teeth during the day or night?	☐	☐
Do your jaw joints click, pop, or make grating noises?	☐	☐
Have you ever been in a vehicle accident or experienced any blows to your jaw?	☐	☐
Have you ever had any implant surgery in one or both of your jaws or jaw joints?	☐	☐
If “yes”, who performed the surgery and when was it done?_______________		
Are you being followed up by a dental specialist?	☐	☐
Do you suffer from headaches? If “yes”, approximately how many per month?_______________	☐	☐
Have you ever had your wisdom teeth removed?	☐	☐
Have you had orthodontic treatment (braces)?	☐	☐
If you play sports, do you wear a mouthguard?	☐	☐

SMILE ANALYSIS

	YES	NO
Are you pleased with the appearance of your teeth?	☐	☐
If not, what would you like to improve? _______________		
Do you have gaps between your teeth that you would like closed?	☐	☐
Would you like to have your teeth whiter?	☐	☐
Do you have chipped or broken teeth which you would like to fix?	☐	☐
Do you have any crooked or misaligned teeth that bother you?	☐	☐

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