FRASER DENTAL GROUP

fraserdentalgroup.com

Medical & Dental History Questionnaire

BEFORE YOUR APPOINTMENT (Please Print)

Last Name_____First_____

Date of Birth (DD/MM/YY)_____

Home Address_____

City_____Province_____Postal Code_____

(H) Phone_____(W) Phone_____

(C) Phone_____

Email_____

Place of Business_____

Occupation_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY

Last Name_____First _____

Relationship_____Daytime Phone_____

1. Name of Family Doctor_____

   Phone or Address_____

2. Name of Specialist_____

   Area of Specialty_____

Phone or Address_____

Do you have Dental Insurance? ☐ Yes ☐ No

How did you hear about our office_____

MEDICAL HISTORY: 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.

PLEASE CHECK ✓

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
   ☐ Yes ☐ No ☐ Not Sure/ Maybe _____
2. When was your last medical checkup? _____
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, 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 yes, please list using the categories below ☐ Yes ☐ No ☐ Not Sure/ Maybe
   ☐ medications _____
   ☐ latex/ rubber products _____
   ☐ other (e.g. hay fever, foods) _____
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? ☐ Yes ☐ No ☐ Not Sure/ Maybe
   If yes, please explain_____
7. Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not Sure/ Maybe
8. Do you have any heart conditions? ☐ Yes ☐ No ☐ Not Sure/ Maybe
9. Do you have or have you ever had any high/ low blood pressure problems? ☐ Yes ☐ No ☐ Not Sure/ Maybe
10. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditic), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ☐ Yes ☐ No ☐ Not Sure/ Maybe
11. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not Sure/ Maybe
12. Do you have any conditions or therapies that could affect your immune system, (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ☐ Yes ☐ No ☐ Not Sure/ Maybe
13. Have you ever had hepatitis, jaundice (other than at birth) or liver disease? ☐ Yes ☐ No ☐ Not Sure/ Maybe
14. Do you have a bleeding problem or a bleeding disorder?
    ☐ Yes ☐ No ☐ Not Sure/ Maybe_____
15. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ rheumatic fever	☐ lung disease	☐ stomach ulcers	☐ drug/alcohol
☐ heart attack	☐ heart murmur	☐ tuberculosis	☐ arthritis	☐ organ transplant
☐ stroke	☐ pacemaker	☐ cancer	☐ seizures (epilepsy)	☐ osteoporosis
☐ shortness of breath	☐ steroid therapy	☐ kidney disease	☐ diabetes	☐ thyroid disease

16. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/ Maybe_____

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?
☐ Yes ☐ No ☐ Not Sure/ Maybe_____

18. Are there any diseases or medical problems that run in your family?(e.g. diabetes, cancer or heart disease)
☐ Yes ☐ No ☐ Not Sure/ Maybe_____

19. Do you smoke or chew tobacco products?
☐ Yes ☐ No ☐ Not Sure/ Maybe How many per day? _____Number of years? _____

FOR WOMEN ONLY

1. Are you pregnant?
☐ Yes ☐ No ☐ Not Sure/ Maybe Expected delivery date?_____
2. Are you breastfeeding? ☐ Yes ☐ No
3. Are you taking birth control medication? ☐ Yes ☐ No

DENTAL HISTORY

1. Last dental visit?_____
2. What was done at that visit?_____
3. How frequently do you see your dentist?_____
4. Have you ever had a full mouth series of X-rays (16 or more X-rays taken at the same time)? ☐ Yes ☐ No
If yes, approximately when? _____
5. How would you describe your dental health at present? ☐ Good ☐ Fair ☐ Poor
6. What are your present dental concerns, if any?

☐ Bleeding gums	☐ Crooked teeth	☐ Cosmetic loose teeth	☐ Stomach ulcers	☐ Bad Breath
☐ Food trapping	☐ Toothache	☐ Missing teeth/ spaces	☐ Loose dentures	☐ Other

7. Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No
8. Have you had any teeth extracted due to accident, decay or gum disease? ☐ Yes ☐ No
If yes, please explain _____
9. If yes, have you had any complications after the extraction? ☐ Yes ☐ No
10. Have you been taught PREVENTIVE ORAL HYGIENE? ☐ Yes ☐ No
11. Are you anxious during dental visits? ☐ Yes ☐ No

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made, payment is due at each office visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist. I authorize the dentist to treat me and I assume fully responsibility for the fees. I am aware that 2 business days of notice is required to change or cancel an appointment without charge.

X _____ _____
SIGNATURE, PARENT OR GUARDIAN IF UNDER 18 DATE

_____ _____
DENTIST'S SIGNATURE DATE