Maplebrook Dental

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 out the entire form. Thank you.

PATIENT INFORMATION

Patient Name:_____
Date of Birthday (DD,MM,YYYY)_____Age:___
Check Box:
Minor ☐ Single ☐ Married ☐ Divorced ☐
Separated ☐ Widowed ☐
Address:

_____
_____
Province_____ Postal code _____
Home Number:(____)_____
Cell Phone:(__)_____Work:(__)_____
Health card: _____
Email Address: _____
Whom may we thank for referring you:

_____

In case of emergency, who can we notify?
Name: _____
Relationship:_____
Day-time phone:_____

Name, phone, address of family doctor:

_____
_____

Name of responsible party for this account:

_____
Relationship to Patient:_____
Birthday (DD,MM,YYYY) _____
Home:(___)_____ Cell:(___)_____
Email address:_____

INSURANCE INFORMATION

Name of Insured *(if different from above)*:

_____
Birthday of Insured: _____
Relationship to Patient: _____
Name of Insurance Company:

_____
Policy Plan #: _____
ID#:_____
How much is your Deductible: _____
Used to date: _____
Annual Maximum: _____
Percentage of coverage: _____

Do you have Secondary coverage?

Name of Insured *(if different from above)*:

_____
Birthday of Insured: _____
Relationship to Patient:_____
Name of Insurance Company:

_____
Policy Plan #: _____
ID#:_____
How much is your Deductible:_____
Used to date: _____
Annual Maximum: _____
Percentage of coverage: _____

DENTAL HISTORY

Is there a dental problem you would like treated immediately? Y/N
If yes, please explain: _____
_____

Are you nervous about seeing a dentist Y/N
Are you unhappy with the appearance of your teeth? Y/N
If yes, what would you like to change? _____
_____

When was your last dental visit (# months/years)? _____
When did you last have dental x-rays? _____
How often do you brush your teeth? _____
How often do you floss your teeth?_____

Does your Child experience any of the following:	YES	NO	NOT SURE
Sleep issues (restless, hard to fall asleep, night terrors)?	☐	☐	☐
Snoring?	☐	☐	☐
Dry Mouth in the morning?	☐	☐	☐
Gums bleed when you brush?	☐	☐	☐
Bedwetting?	☐	☐	☐
History of respiratory infection (tubes in ears, frequent colds, sore throats)?	☐	☐	☐
Grinding/clenching?	☐	☐	☐
Habits such as Pacifier, Sippy cup, sucking of thumb or finger (circle one)	☐	☐	☐
Trouble focusing or behaviour	☐	☐	☐

Please list anything else not mentioned above regarding your past dental history.
_____
_____

MEDICAL HISTORY

Patient Name:_____ Today's date:_____/____/_____

1. Are you being treated for any medical conditions at the present time, or have you been treated within the past year? If so, why? ☐ Yes ☐ No

   _____

2. When was your last medical check up? _____

3. Are you taking any a medication, non-prescription drugs, or herbal supplements of any kind? ☐ Yes ☐ No
   If yes, please list: _____

4. Do you have any allergies? If you answer yes, please list according to the categories below: ☐ Yes ☐ No
   Medications/injections: _____
   Latex/rubber products: _____
   Other (hay fever, food etc.) _____

5. Do you have or have ever had asthma? Bronchitis? Pneumonia? (If yes please circle which) ☐ Yes ☐ No

6. Do you have or have ever had any heart or blood pressure problems? ☐ Yes ☐ No

7. Have you ever had any heart infection (infective endocarditic) heart valve repair or replacement congenital heart disease (from birth)? ☐ Yes ☐ No

8. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No

9. Do you have any conditions or therapies that could affect your immune system? (i.e. AIDS, HIV, Radiotherapy, Chemotherapy?) ☐ Yes ☐ No ☐ Not sure

10. Have you ever had hepatitis, Jaundice or Liver disease? ☐ Yes ☐ No ☐ Not sure

11. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not Sure

12. Have you ever had any operations? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure

    _____

13. Do you have or have you ever had any of the following? Please Check

☐ chest pain, angina	☐ shortness of breath	☐ heart murmur	☐ steroid therapy	☐ seizures (epilepsy)	☐ drug/alcohol dependency
☐ heart attack	☐ rheumatic fever	☐ pacemaker	☐ diabetes	☐ kidney disease	☐ osteoporosis medications (e.g. Fosamax, Actonel)
☐ stroke	☐ mitral valve prolapse	☐ lung disease	☐ stomach ulcers	☐ thyroid disease	
		☐ tuberculosis	☐ arthritis		
		☐ cancer			

14. Are there any conditions or diseases you have had not listed above? ☐ Yes ☐ No ☐ Not sure

    If yes, please list _____

15. Are there any diseases or conditions that run in your family? ☐ Yes ☐ No ☐ Not Sure

16. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure

17. For women only: Are you breast-feeding or pregnant? ☐ Yes ☐ No ☐ Not Sure

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

_____ Date:_____/____/_____
Patient/Parent/Guardian/Signature Month Day Year

_____ Date:_____/____/_____
Dentist's Signature Month Day Year