WELCOME TO HUNTER DENTAL

34A Main St., Markham, ON, L3P 1X5
Phone: 905-294-3444

For office use only
ID # _____
MEDICAL ALERT Y ☐ N ☐

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. **PLEASE PRINT.**

REGISTRATION INFORMATION

This information will enable us to maintain communication with you. **DATE:** _____

The patient is an: Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian: _____

Name: _____ Dr. ☐ Mr.☐ Mrs. ☐ Ms. ☐ Miss ☐

Prefers to be called: _____ Language Preference:_____

Address: _____

Home Phone: ( ) _____ Additional registration information if required by office:_____

Bus. Phone: ( ) _____ Ext. _____ Employer: _____ May we call you at work? _____

Cell Phone: ( ) _____ Pager No. ( ) _____ Email Address: _____

Date of Birth: M ____ D ____ Y _____ Age:_____ Sex: _____ Marital Status: _____ Name of Spouse: _____

Preferred appointment time: _____ Whom may we thank for referring you?_____

Are other family members patients at our office? Yes ☐ Names: _____

MEDICAL PRIORITY

This information will enable us to make any essential contacts.

Family Physician: _____ Phone: ( )_____

Medical Specialist: _____ Phone: ( )_____

In case of emergency, please contact:_____ Phone: ( )_____

Nearest relative not living with you:_____ Phone: ( )_____

Reason for today's visit? Examination ☐ Emergency ☐ Other ☐ _____

Is there a dental problem you would like treated immediately? _____

FINANCIAL INFORMATION

This information is necessary to process invoices and apply payments.

Person responsible for account: Self ☐ Spouse ☐ Other ☐ Please complete all information only if different than above.

Name: _____ Phone: ( )_____

Address:_____

Employed by: _____ Phone : ( )_____

Additional financial information if required by office:_____

METHOD OF PAYMENT (For office use only) CASH ☐ CHEQUE ☐ CREDIT CARD ☐ OTHER ☐

PRIMARY DENTAL INSURANCE

(Complete information only if required by office)

Subscriber's Name: _____ D.O.B. _____

Emp. Grp. policy holder: _____ Ins. yr. end _____

Ins. Co. _____ Tel: _____

Grp./Ind. policy No.: _____ Cert No. _____

ID#_____ Max Coverage: _____

% coverage: Basic _____ Maj. Rest. _____ Ortho. ____ Other___

SECONDARY DENTAL INSURANCE

Subscriber's Name: _____ D.O.B. _____

Emp. Grp. Policy: _____ Ins. yr. end _____

Ins. Co. _____ Tel: _____

Grp./Ind policy No.: _____ Cert No. _____

ID#_____ Max Coverage: _____

% coverage: Basic _____ Maj. Rest. _____ Ortho. _____ Other _____

PATIENT REGISTRATION **DENTAL HISTORY**

DENTAL HISTORY

Please ✓ YES or NO to each question. If unsure of a question, please consult with the dentist.

	YES	NO
Is there a dental problem you would like treated immediately? Yes ☐ No ☐ _____		
Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays?_____		
1. Have you been seeing a dentist regularly? _____	☐	☐
2. Have you ever had any of the following?		
- Periodontal Treatment? (treatment of the gums) _____	☐	☐
- Orthodontic Treatment? (to straighten or realign teeth) _____	☐	☐
- A bite plate or any other appliance? _____	☐	☐
- Your bite adjusted or teeth ground? _____	☐	☐
- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)		
If you answered "yes" to the last question, who performed the surgery? _____ When? _____	☐	☐
Are you being followed up by a dental specialist?_____	☐	☐
3. Are there any growths or sore spots in your mouth? _____	☐	☐
4. Do your gums bleed when brushing or eating, or. do you suffer from pain or swelling of your gums? _____	☐	☐
5. Have you noticed any loose teeth, or. have any of your teeth shifted? _____	☐	☐
6. Does food catch between your teeth? _____	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____	☐	☐
8. Have you been advised to take antibiotics before a dental appointment? _____	☐	☐
9. Do you use dental floss, proxabrush or stimudents? How often? _____	☐	☐
10. How often do you brush your teeth? _____ Do you feel that you have bad breath? _____	☐	☐
11. Have you ever experienced any of the following jaw problems:		
- Popping/clicking in your jaw joints? _____	☐	☐
- Pain in your jaw joints, around your ear, or side of your face? _____	☐	☐
- Difficulty in opening or closing? _____	☐	☐
- Pain when teeth are clenched? _____	☐	☐
- Pain or difficulty while chewing? _____	☐	☐
12. Do you have any of the following habits?		
- Clenching or grinding your teeth while awake or asleep? _____ _____	☐	☐
- Biting your cheeks or lips? _____	☐	☐
- Mouth breathing while awake or asleep? _____	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? _____	☐	☐
13. Do you have any emotional concerns about having dental treatment? _____	☐	☐
14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or. do you have any questions or concerns? _____	☐	☐
15. Are you unhappy with the appearance of your teeth? _____	☐	☐
and. What would you like to see changed? _____	☐	☐
16. Do you feel your dental health influences your overall health?_____		
17. On a scale of 1 to 10. 10 being highest, how important is it for you to keep your natural teeth? _____	☐	☐

GENERAL RELEASE

(Please sign after completing medical questionnaire.)

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly-omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I** authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by Treating Dentist: _____ Date: _____

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