Capitol DENTISTRY

WELCOME TO OUR DENTAL OFFICE

(For Office Use Only)

I.D. #
MEDICAL ALERT ☐ Y ☐ N

Date: ____________________

The information that is requested on the 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 collection, using and disclosing this information responsibly. PLEASE PRINT

REGISTRATION INFORMATION – *This information will enable us to maintain communication with you.*

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

Name:____________________ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐
Prefers to be called: ____________________ Language Preference: ____________________

Address: *(Street)* *(Apt.)* *(City)* *(Prov.)* *(Postal Code)*

Home Phone: ( ) ____________________ Cell: ( ) ____________________
Email:____________________ Business: ( )____________________
May we call work? ☐ Y ☐ N
Employer: ____________________ Date of Birth: M ________ D: ____ Y: ________
Age: ______ Sex: ______ Marital Status:__________ Name of Spouse: ____________________
Preferred Appt. Time: ____________________ Referred by: ____________________
Are other family members patients at our office: Yes ☐ Names:____________________

MEDICAL HISTORY – *This information will enable us to make any essential contact.*

Family Physician:____________________ Phone: ( )____________________
Medical Specialist: ____________________ Phone: ( )____________________
(if presently under care)
In case of emergency, please contact:____________________ Phone: ( )____________________
Nearest relative not living with you:____________________ Phone: ( )____________________

Reasons 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 if different than above.

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Name: ______________________ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐

Prefers to be called: ______________________ Language Preference: ______________________

Address: *(Street)* *(Apt.)* *(City)* *(Prov.)* *(Postal Code)*

____

Home Phone: ( ) ______________________ Cell: ( ) ______________________

Email: ______________________ Business: ( ) ______________________

May we call work? ☐ Y ☐ N

Employer: ______________________

METHOD OF PAYMENT *(for office use only):*

CASH ☐ CHEQUE ☐ CREDIT CARD ☐ OTHER ☐

PRIMARY DENTAL INSURANCE

(If information required by office)

Subscriber's Name ____________ D.O.B ____________

Empl./Grp. Policy Holder: ____________

Ins. Yr. End ____________

Ins. Co. ____________ Tel.: ____________

Grp./Ind. Policy No.: ____________

Cert. No.: ____________ Max Coverage: ____________

% Coverage Basic ________ Maj. Rest: ____________

Ortho.: ____________ Other: ____________

SECONDARY DENTAL INSURANCE

Subscriber's Name ____________ D.O.B ____________

Empl./Grp. Policy Holder: ____________

Ins. Yr. End ____________

Ins. Co. ____________ Tel.: ____________

Grp./Ind. Policy No.: ____________

Cert. No.: ____________ Max Coverage: ____________

% Coverage Basic ________ Maj. Rest: ____________

Ortho.: ____________ Other: ____________

HEALTH HISTORY – *Please check (✓) YES or NO to each question. If unsure of a question, please consult with the dentist.*

1. Are you being treated for any medical conditions at recent or within the last 2 years? YES ☐ NO ☐
   If yes, please explain: ____________ Physician: ____________ Phone: ____________
2. Have you been hospitalized in the last 2 years? ____________ YES ☐ NO ☐
3. When was your last visit to a physician? ____________ Last Physical Exam? ____________
4. Have you recently, or are you presently, taking any **prescription** or **non-prescription** drugs including herbal remedies? ____________ YES ☐ NO ☐
5. Have you ever reacted adversely to any medications or injections? YES ☐ NO ☐
   Penicillin, or antibiotics ☐ Aspirin ☐ Codeine ☐ Local Anaesthetic ☐
   Nitrous Oxide ☐ Or any other medications ☐ ____________
6. Have you ever been advised against taking any specific type of medication? YES ☐ NO ☐
   If so, please specify: ____________
7. Do you have any of the following?
   Asthma ☐ Hay Fever ☐ Food Allergies ☐ Metal or Latex Allergies ☐
   Skin Rashes ☐ Hives ☐ Or any other allergic conditions ☐ ____________
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so please explain ____________ YES ☐ NO ☐
9. Is there any family history of Diabetes, Cancer or Heart Disease? ____________ YES ☐ NO ☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? ____________ YES ☐ NO ☐
11. Do your ankles, feet or hands swell? ____________ YES ☐ NO ☐

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12. Has your weight, appetite, or energy level changed dramatically recently?________ YES ☐ NO ☐
13. Do you follow a special diet or are you on a diet pill therapy?________________ YES ☐ NO ☐
14. Do you experience shortness of breath or chest pain when taking a walk or climbing? YES ☐ NO ☐
15. Have you tested H.I.V. positive? YES ☐ NO ☐
16. Do you have FREQUENT SEVERE headaches earaches, ear/throat infections? YES ☐ NO ☐
17. Have you ever had any injury to your face or jaw?________________________ YES ☐ NO ☐
18. Do you wear glasses or contact lenses? ________________________________ YES ☐ NO ☐
19. Do you have any hearing difficulties? YES ☐ NO ☐
20. Do you smoke or use any other forms of tobacco? ________________________ YES ☐ NO ☐
Are you wearing a nicotine patch? YES ☐ NO ☐
21. Are you alcohol and/or drug dependent?________________________________ YES ☐ NO ☐
And, have you received treatment?____________________________________ YES ☐ NO ☐

22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

Condition	YES	NO
A.I.D.S	YES ☐	NO ☐
Anaemia	YES ☐	NO ☐
Angina Pectoris	YES ☐	NO ☐
Arthritis/Rheumatism	YES ☐	NO ☐
Artificial Joints	YES ☐	NO ☐
Blood Disorder	YES ☐	NO ☐
Bronchitis	YES ☐	NO ☐
Cancer	YES ☐	NO ☐
Circulation Problems	YES ☐	NO ☐
Heart Disease	YES ☐	NO ☐
Lesions	YES ☐	NO ☐
Cortisone/Steroid	YES ☐	NO ☐
Crohn's Disease	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐
Emphysema	YES ☐	NO ☐
Epilepsy or Seizures	YES ☐	NO ☐
Fainting/ Dizzy Spells	YES ☐	NO ☐
Radiation Treatment/Chemo	YES ☐	NO ☐
Venereal Disease	YES ☐	NO ☐

Condition	YES	NO
Glaucoma	YES ☐	NO ☐
Head/Neck Injury	YES ☐	NO ☐
Heart Disease/ Attack	YES ☐	NO ☐
Heart Murmur	YES ☐	NO ☐
Heart Pacemaker	YES ☐	NO ☐
Heart Rhythm Disorder	YES ☐	NO ☐
Heart Surgery	YES ☐	NO ☐
Hepatitis A B C __	YES ☐	NO ☐
Herpes	YES ☐	NO ☐
High/Low BP	YES ☐	NO ☐
Hodgkin's Disease	YES ☐	NO ☐
Hyper/Hypo Glycemia	YES ☐	NO ☐
Hypertension	YES ☐	NO ☐
Inflammatory Bowel Disease	YES ☐	NO ☐
Jaundice	YES ☐	NO ☐
Kidney Disease	YES ☐	NO ☐
Liver Disease	YES ☐	NO ☐
Glandular Disease	YES ☐	NO ☐
Lung Disease	YES ☐	NO ☐

Condition	YES	NO
Lupus	YES ☐	NO ☐
Malignant Hyperthermia	YES ☐	NO ☐
Mental/Nervous	YES ☐	NO ☐
Disorder	YES ☐	NO ☐
Mitral Valve Prolapse	YES ☐	NO ☐
Organ Transplant/Implant	YES ☐	NO ☐
Psychiatric Treatment	YES ☐	NO ☐
Scarlet Fever	YES ☐	NO ☐
Sickle Cell Disease	YES ☐	NO ☐
Sinus Trouble	YES ☐	NO ☐
Stomach/Intestinal Problems	YES ☐	NO ☐
Ulcers	YES ☐	NO ☐
Stroke	YES ☐	NO ☐
Thyroid Disease	YES ☐	NO ☐
Tuberculosis	YES ☐	NO ☐
Other	YES ☐	NO ☐
______________________		

23. Has your CHILD PATIENT <u>recently</u> had the following: *(please indicate approximate date)*

Measles
YES ☐ NO ☐ ______________
Mumps
YES ☐ NO ☐ ______________
Tonsillitis
YES ☐ NO ☐ ______________
Chicken Pox
YES ☐ NO ☐ ______________
Strep Throat
YES ☐ NO ☐ ______________

24. Do you currently have, or have you had any disease or problem not listed above? YES ☐ NO ☐
Explain:____

25. Is there anything else about your health that we should be aware of? YES ☐ NO ☐
Explain:____

26. Do you wish to speak privately to the Doctor about any problem or medical condition?
YES ☐ NO ☐

27. **WOMEN ONLY:**
Are you pregnant or suspect you may be? YES ☐ NO ☐ Expected due date?__________________

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Are you breast feeding? YES ☐ NO ☐ Are taking Birth control Pills? YES ☐ NO ☐

NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE

MEDICAL ALERT	Condition	Premedication	Allergies	Anaest.

DENTAL HISTORY – *Please check (✓) YES or NO to each question. If unsure of a question, please consult with your dentist.*

Is there a dental problem you would like treated immediately? YES ☐ NO ☐
If yes, explain: ______________________________

Date of your last dental visit? ____________ Last dental cleaning? __________ Last x-rays? ____________

1. Have you been seeing a dentist regularly? YES ☐ NO ☐
2. Have you ever had any of the following?
   Periodontal Treatment (treatment of the gums)? YES ☐ NO ☐
   Orthodontic Treatment (to straighten/realign teeth)? YES ☐ NO ☐
   A bite plate or any other appliance? YES ☐ NO ☐
   Your bite adjusted or teeth ground? YES ☐ NO ☐
   Oral surgery: YES ☐ NO ☐
   (Surgery in or about the mouth/jaw, or implant surgery in one or both of your jaw joints)?
   If you answered "yes" to the last question, who performed the surgery? ____________ When? ____________
3. Are there any growths or sore spots in your mouth? YES ☐ NO ☐
4. Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums? YES ☐ NO ☐
5. Have you noticed any loose or shifted teeth? YES ☐ NO ☐
6. Does food catch between your teeth? YES ☐ NO ☐
7. Are any of your teeth sensitive to heat, cold, sweet or pressure? YES ☐ NO ☐
8. Have you been advised to take antibiotics before a dental appointment? YES ☐ NO ☐
9. Do you floss? How often? YES ☐ NO ☐
10. How often do you brush? __________ Do you feel that you have bad breath? YES ☐ NO ☐
11. Have you ever experienced any of the following jaw problems?
    Popping/clicking in your jaw joints? YES ☐ NO ☐
    Pain in your jaw joints, around your ear, or side of your face? YES ☐ NO ☐
    Difficulty opening or closing your mouth? YES ☐ NO ☐
    Pain when teeth are clenched? YES ☐ NO ☐
    Pain or difficulty while chewing? YES ☐ NO ☐
12. Do you have any of the following habits?
    Clenching or grinding your teeth while awake or asleep? YES ☐ NO ☐
    Biting your cheeks or lips? YES ☐ NO ☐
    Mouth breathing while awake or asleep? YES ☐ NO ☐
    Placing foreign objects in your mouth (pencils, nails, pins)? YES ☐ NO ☐
13. Do you have any emotional concerns about having dental treatment? YES ☐ NO ☐
14. Are you unhappy with the appearance of your teeth? YES ☐ NO ☐
    What would you like to see changed? ______________________________
15. Have you ever had an upsetting experience in a dental office, or any complications during or following a dental treatment, or do you have any questions or concerns? ______________________________
    ____