WELCOME TO THE 404 DENTAL OFFICE

PERSONAL HISTORY

Name: _____ Date of Birth (MM/DD/YY) _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

E-Mail Address: _____

Occupation and Employer: _____

Insurance Carrier: _____ Group #: _____

MEDICAL HISTORY

1. Are you under the care of a physician now? YES or NO

Family Physician: _____

2. Have you had any serious illness or injury? YES or NO

3. Have you had a complete physical examination in the past year? YES or NO

4. Do you use any medication now? YES or NO Prescription / Non-prescription?

Present Medications: _____

5. Have you ever had any unusual reaction to any drugs / medication? YES or NO

Medication/ Allergies: _____

6. Have you ever had or do you have any of the following illnesses / conditions?

☐ Hepatitis	☐ Headaches	☐ Jaundice	☐ Eye Glasses/Contacts
☐ Stroke	☐ High Blood Pressure	☐ Smoke	☐ Low Blood Pressure
☐ Tuberculosis	☐ Migraines	☐ Anaemia	☐ STI
☐ Rheumatism	☐ Alcohol/ Drug Addiction	☐ Epilepsy	☐ Stomach Problems
☐ Asthma	☐ Thyroid Disease	☐ Hay Fever	☐ Kidney Disease
☐ AIDS or HIV	☐ Liver Disease	☐ Diabetes	☐ Eating Disorders
☐ Blood Disorder	☐ Mental or Nervous Disorder	☐ Arthritis	☐ Hearing Aid

☐ Food/ Environment Allergies: _____ Do you carry an Epi-Pen? YES or NO

☐ Genetic Syndromes: _____

☐ Other: _____

☐ Other: _____

7. Have you ever had any heart condition? YES or NO

☐ Heart Attack	☐ Artificial Heart Valves
☐ Heart Murmur	☐ Heart Surgery
☐ Heart Disease	☐ Cardiac Pacemaker

Have you been advised to take antibiotics before any dental work? YES or NO

8. Do you have any prosthetic implants? YES or NO

9. Have you ever been treated for any type of Cancer? If yes, what type? _____

10. Have you had any unusual reaction to local / general anaesthetic / nitrous oxide sedation? YES or NO

11. Do you have any family history of Malignant Hyperthermia? YES or NO

12. Do you take birth control pills? YES or NO

Are you pregnant or suspect that you may be? YES or NO If yes how many months? _____

Date: _____ Signature: _____

404 DENTAL — DENTAL HISTORY

What brings you to see us today? _____

How did you hear about the office? _____

What are your expectations of us as your dental care providers? _____

_____

What are your goals for your teeth, your mouth, and your smile? _____

_____

Share with us some of your experiences in your previous dental offices. Things you liked? Things you disliked?

_____

_____

On a scale of 1 to 10, how important is it for you to keep your teeth? (10 most important) _____

When was your last dental visit? _____

When was your last appointment? _____

What has been the focus of your past dental hygiene care? _____

When was your last set of x-rays taken? _____

What does your current homecare routine include?

- ☐ Electric brush
- ☐ Floss
- ☐ Sulca brush
- ☐ Stimudents
- ☐ Other: _____
- ☐ Manual brush how often- 1 2 3 4 5x/day
- ☐ Proxabrush
- ☐ Rinse
- ☐ Toothpicks
- ☐ Other: _____

Have you ever been told you have gum disease? YES or NO

Do your gums bleed with brushing or flossing? YES or NO

Have you ever had orthodontic treatment? YES or NO

Have you had your wisdom teeth extracted? YES or NO

Have you ever had gum surgery? YES or NO

Are there any areas of your mouth that concern you at this time? Any discomfort or sensitivity? _____

_____

What questions can we answer for you? _____

_____