**MEDICAL AND DENTAL QUESTIONNAIRE FOR ADULTS**   
The following information is required to thoroughly diagnose and give you personal attention. Please fill out the form completely.

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| **PERSONAL INFORMATION**  Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last First Middle DD/MM/YYYY Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PostalCode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (HM)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(WK)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_ In case of emergency, Notify: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation\_\_\_\_\_\_\_\_\_\_\_ Personal Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Po.#(cert..and/or group)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIN of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where Insured works\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to insured: **□Son □ Daughter □Spouse □ Other** | | |
| **PRESENT STATE OF HEALTH**  1. Do you consider yourself in good health?...................................................................................................................... 2. Are you presently under observation or treatment for any complaint (medical or dental? ……………………………………..  3. Are you taking ANY drugs or medications, either prescribed or self? ………………………………………………………………………  If yes, please circle: Tranquilizers; aspirins; diuretics; sleeping pills; heart pills; birth control; steroids;  Others: 4. Have you noticed any excess fatigue from normal work?.............................................................................................  5. Have you had any changes in your appetite? ...............................................................................................................  6. Are you on any special diet? ......................................................................................................................................... 7. Has your weight been constant? .................................................................................................................................. 8. At room temperature, do you normally feel either cold or very warm? ..................................................................... 9. Have you noticed any on the following? (Please circle)…………………………………………………………………………………………….  ankles swelling; sleeping poorly; needing more than one pillow to sleep; going to the washroom often.  at night; bruising easily; bleeding for a long time  10. Do you have ANY allergies? Hay fever, asthma, others? ............................................................................................ 11. Do you have ANY sensitivity or allergies to any drugs? ..............................................................................................  12. (FOR WOMEN ONLY) Are you pregnant? What month? ............................................................................................. | **□ YES □ YES □ YES   □ YES □ YES □ YES □ YES □ YES □ YES   □ YES □ YES □ YES** | □ **NO □ NO**  **□ NO   □ NO □ NO □ NO □ NO □ NO □ NO   □ NO □ NO □ NO** |
| **MEDICAL HISTORY**  1. Do you have or have you had? (Please circle) Heart trouble; high blood pressure; kidney trouble; liver trouble  (E.G) Jaundice, hepatitis); epilepsy; thyroid trouble; tuberculosis; asthma; blood disorders; diabetes; anemia;  Pace maker; prosthetic valve; psychiatric Rx; venereal disease; Aids; HIV; antibody; cancer; others………………………… 2. Have you ever been hospitalized?  If so when and why? .......................................................................................................................................................... 3. Have you ever had any other serious illness? (Please specify)………………………………………………………………………………… 4. Have you ever had rheumatic fever? ............................................................................................................................ 5. Have you ever had cardiac surgery? ………………………………………………………………………………………………………………………… 6. Have you ever taken steroids? ………………………………………………………………………………………………………………………………… 7. Have you ever had any injury, surgery or radiation therapy to you head, face, or jaw? ………………………………………….. 8. Have you ever had any hip/ knee/ elbow replacements? ………………………………………………………………………………………... 9. Your last blood sample taken? Reason | **□ YES   □ YES □ YES □ YES □ YES □ YES □ YES □ YES** | **□ NO   □ NO □ NO □ NO □ NO □ NO □ NO □ NO** |
| **DENTAL HEALTH** 1. When was your last dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what reason?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Have you ever had (please circle): a tooth removed; local anaesthetic(freezing); general anaesthetic; orthodontic Rx; periodontal Rx; root canal Rx; dentures; crowns? …………………………………………………………………………………………………  3. Have you ever had any ill effects from freezing?. ......................................................................................................... 4. Are you tense during dental visits….If yes, which part makes you tense?..................................................................... 5. Do you chew easily and thoroughly? ………………………………………………………………………………………………………………………. 6. Are you conscious of bad breath or a bad taste in your mouth? ……………………………………………………………………………… 7. Do your gums bleed when you brush your teeth? …………………………………………………………………………………………………… 8. Are you satisfied with the appearance of your teeth and smile? …………………………………………………………………………..... 9. Are you anxious to keep your natural teeth?............................................................................................................... 10. Do you consider your teeth beyond treatment? ……………………………………………………………………………………………………. | **□ YES □ YES  □ YES □ YES □ YES □ YES □ YES □ YES □ YES □ YES** | **□ NO □ NO  □ NO □ NO □ NO □ NO □ NO □ NO □ NO □ NO** |

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| **YOUR ACCOUNT**  □ If you do not have dental insurance, then payment is due as services are rendered.  □ If you have dental insurance, and are regular patients at our office, we allow a courtesy period for our office to receive reimbursement from your insurance company.   Remember that your dental plan is a contract between your insurance company and you, not your dentist. Like any contact, beware of the *fine print.* For example, many plans claim 100% coverage but may have a deductible, or may not cover all procedures, or may use an outdated Ontario Dental Association Fee Schedule. You are responsible for their uninsured portions. Please bring your booklets and questions to our staff who will be glad to assist you.  □There will be a $ 100.00 charge per patient if patient does not show up for confirmed appointment.  **PERMIT FOR OPERATIONS**  This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures as agreed to between myself and the dentist, and will assume responsibility for fees (or if I have insurance, the uninsured portions of the fees) associated with those procedures.  **Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |