



MEDICAL ALERT

WELCOME TO OUR DENTAL OFFICE

Date _____

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our team is available to assist you with the completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

The patient is an: Adult [] Under guardianship [] Name of Guardian: _____

Name: _____ Dr. [] Mr. [] Mrs. [] Ms. [] Miss []

Address: _____

Reason for today's visit? Examination [] Other [] _____

Preferred appt. time? _____

Home Phone: () _____ Bus Phone: () _____ Ext. _____ May we call you at work? []

Would you be able to attend an appointment on short notice? Y [] N []

PERSONAL INFORMATION

Prefers to be called: _____ Occupation: _____

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

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

How did you hear about our office? [] Friend/Relative [] Advertising [] Other _____

Whom may we thank for referring you? _____

MEDICAL PRIORITY

Family Physician: _____ Phone: () _____

Medical Specialist: _____ Phone: () _____

Other Dentist: _____ Phone: () _____

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

FINANCIAL INFORMATION

Person responsible for account: Self [] Spouse [] Other [] _____ Please complete all information if different than above.

Name: _____ Phone: () _____

Address: _____

Employed by: _____ Phone: () _____

[] I am interested in information regarding payment plans for my dental care.

PRIMARY DENTAL INSURANCE

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

Relationship to Subscriber _____ Ins. yr. end/Calendar yr. _____

Ins. Co. _____

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

I.D./S.I.N. _____

Notes _____

SECONDARY DENTAL INSURANCE

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

Relationship to Subscriber _____ Ins. yr. end/Calendar yr. _____

Ins. Co. _____

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

I.D./S.I.N. _____

Notes _____

PATIENT REGISTRATION

DENTAL HISTORY

DENTAL HISTORY

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

- Is there a dental problem you would like treated immediately? Yes Problem: _____ No
Are there any other dental conditions that concern you at present? Yes Condition: _____ 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? (please circle)
-Periodontal Treatment? (treatment of the gums) -Dentures or Partial Dentures? (circle)
-Orthodontic Treatment? (to straighten or realign teeth) -Wisdom Teeth Removal?
-A bite plate, night guard or any other appliance? -Root Canal Treatment?
-Crowns or Bridges?
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? (circle) _____
8. 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? _____
9. Do you have headaches? Yes No Migraine? Yes No How often? _____ For how long? _____
Medication taken (amount and frequency) _____
Circle other symptoms: Neckaches, Ringing in the ears, Numbness or tingling fingertips, Blurred vision, Fatigue,
Dizziness, Ear congestion, Nausea, Sensitivity to light
10. Circle if you have the following habits: Clenching teeth, Grinding teeth, Cheek/Lip biting, Mouth breathing, Tongue habit, Snore, Gag reflex
11. Are you missing any teeth? Yes No If so, have they been replaced? Yes No If not, would you like them replaced? Yes No
12. Is there anything you would like to change about the appearance of your teeth? Yes What? _____ No
13. Do you have any concerns about halitosis (bad breath)? _____
14. Are you interested in any of the following? (Please ✓)
 Teeth whitening or bleaching Cosmetic dentistry
 Treatment of bad breath (halitosis) Digital imaging (computer modification of a digital photograph of
your teeth to show you what changes would look like)
 Orthodontic treatment
15. 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? _____

16. Please place a mark on the line below indicating the degree of anxiousness you experience when having dental work done.
Not anxious at all _____ Greatest amount of anxiety imaginable

OFFICE POLICY

APPOINTMENTS
Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore at least 2 WORKING DAYS NOTICE must be given if rescheduling is absolutely necessary.

PAYMENT OF FEES
1. Payment for services is due the day of your appointment.
2. For appointments longer than one hour, prepayment is required to reserve your time.
3. We will supply a computerized printout of work done for your insurance claim along with a stamped envelope for you to submit. We will help you maximize your insurance benefits but Dr. Heit will treatment plan your ideal dental needs to your presenting condition and not to what your insurance will or will not cover.
4. You are responsible for providing the necessary information in order for us to bill your insurance company on your behalf as well as informing us of any changes in this information.

GENERAL RELEASE
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 consent to the collection, use or disclosure of personal information as required for my own or my dependants dental care.
I authorize Dr. Heit to submit a letter of notification of treatment on progress to my medical doctor, other dentist or specialist, insurance company or lawyer.

CONSENT
I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and consent to the use of local anaesthetic agents. I understand the above statements regarding the payment of fees and accept the responsibility for payment for Dental Services provided for myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

Patient Signature: _____ Date: _____ Witness: _____
Parent or Responsible Party: _____ Relationship to Patient: _____

Last Name:	First	Middle
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Please ✓ YES or NO to each question. If unsure of a question, please consult with the dentist or receptionist.

1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____

2. Have you been hospitalized in the past two years? _____
3. When was your last visit to a Physician? _____ Last complete physical examination? _____
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs including vitamins or naturopathic substances? Please list:
 1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____
5. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Keflex, Dalacin, Sulfa, or other antibiotics, ASPIRIN, VALIUM, CODEINE, NARCOTICS, LOCAL ANAESTHETIC (freezing), any other medicine: _____
6. Have you ever been advised against taking any specific type of medication? _____
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: _____
9. Have you been advised by your Medical Doctor or Dentist to take antibiotics prior to dental treatment? _____
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____
11. Do your ankles, feet or hands swell? _____
12. Are you thirsty much of the time or urinate more than 6 times per day? _____
13. Has your weight, appetite or energy level changed dramatically recently? _____
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____
15. Have you tested HIV positive, or come in contact with the AIDS virus? _____
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____
17. Have you ever had any injury or surgery to your face or jaws? _____
18. Have you had any other surgeries? _____

19. Do you smoke or use any other forms of tobacco? _____
20. Are you alcohol and/or drug dependent? _____
and, Have you received treatment? _____

21. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD: (please circle)

- | | | |
|-------------------------------|-------------------------|----------------------------------|
| Anemia | Headaches | Malignant Hyperthermia |
| Angina pectoris | Heart disease or attack | Metal allergy |
| Arthritis/rheumatism | Heart murmur | Migraines |
| Artificial heart valve | Heart pacemaker | Mitral valve prolapse |
| Artificial joints (hip, knee) | Heart rhythm disorder | Organ transplant/medical implant |
| Blood disorders | Heart surgery | Psychiatric treatment |
| Bronchitis | Hepatitis A | Radiation treatment/chemotherapy |
| Cancer | Hepatitis B | Rheumatic/Scarlet fever |
| Circulation problems | Hepatitis C | Sickle cell disease |
| Congenital heart lesions | HIV | Sinus trouble |
| Cortisone/steroids | High/Low blood pressure | Stomach/intestinal problems |
| Diabetes | Hodgkins disease | Stroke |
| Emphysema | Hyper (Hypo) Glycemia | Temporal Arteritis |
| Epilepsy or seizures | Jaundice | Thyroid disease |
| Fainting or dizzy spell | Kidney disease | Tuberculosis |
| Glandular disorders | Latex allergy | Ulcers |
| Glaucoma | Liver disease | Other _____ |
| Head/neck injuries | Lung disease | Other _____ |

22. Is there a family history of any of the above conditions? _____

23. WOMEN ONLY: Are you pregnant or suspect you may be? _____
 Are you breastfeeding? _____ Are you taking any birth control pills? _____

24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____
 25. Is there anything else about your health we should be made aware of? _____
 26. Do you wish to speak to the Doctor privately about any problem or medical condition? _____

For Doctor's Use: Fit for treatment _____

MEDICAL HISTORY

MEDICAL HISTORY UPDATES