

WELCOME TO DENTISTRY ON THE "Q" (Where Dentistry in an Art)

PATIENT INFORMATION FORM MEDICAL ALERT _____ PRE-MED _____

In order to provide safe dental care for our patients, we are asking you to fill out the following information & questionnaire. Please answer the questionnaire as accurately as you can. If you have questions or doubts, check the not sure/maybe choice. Your responses will be reviewed with you by the dental providers. You can be assured that the information that you provide will be kept in the strictest confidence.

Last Name: _____ **First Name:** _____ **Initial** _____

Address: _____ **City:** _____ **Prov:** _____ **Postal Code** _____

Date of Birth: Day ____ **Month** _____ **Year** _____ **Age** ____ **Sex** _____ **Marital Status** _____

Home #: _____ **Bus #:** _____ **Cell #** _____ **Email:** _____

Family Physician: _____ **Telephone Number:** _____

Person Responsible for account: Self ____ Other ____ **Name:** _____ **Tel. No.** _____
Address: _____ **Bus. No.** _____

In case of emergency, please contact: _____ **Relationship:** _____
Telephone Number: _____ **Business Number:** _____

Reason for your visit: Examination **Emergency** **Other:** _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

DENTAL HISTORY QUESTIONNAIRE

When was your last dental visit? _____ **Last Dental Cleaning?** _____

When did you have you last dental x-rays? _____

How often do you brush your teeth? _____, **floss your teeth?** _____

	YES	NOT SURE/ MAYBE	NO
Have you been seeing a dentist regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been advised to take antibiotic before dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any pain when you chew?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been in a vehicle accident or experienced blow to your jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any implant surgery in one or both of your jaws or jaw joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you answered "yes" to the last question, who performed the surgery and when was it done? _____			
Are you being followed-up by a dental specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please list anything else not mentioned above regarding your past dental history? _____			

MEDICAL QUESTIONNAIRE

	Yes	Not Sure/	No Maybe
Are you being treated for any medical condition at the present or have you been treated within the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had cancer treatment or treatment for Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a prosthetic or artificial joint? If yes, when _____			
When was your last medical check-up? _____			
When was your last visit to a physician. Please give reason. _____			
Has there been any change in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medication or non-prescription drugs of any kind? If yes, please list them: _____			
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a peculiar or adverse reaction to any medicines or injections? (e.g. penicillin, aspirin or local anaesthetics, dental freezing?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any heart or blood pressure problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a heart murmur or mitral valve prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had jaundice, hepatitis or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you should not give blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any conditions that could affect your immune system, e.g. AIDS, HIV positive, leukemia, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized for any serious illnesses or operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had any of the following? Please tick off only those that apply:			
<input type="checkbox"/> chest pain	<input type="checkbox"/> bronchitis	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> asthma
<input type="checkbox"/> epilepsy	<input type="checkbox"/> diabetes	<input type="checkbox"/> stroke	<input type="checkbox"/> heart attack
<input type="checkbox"/> prosthetic joint	<input type="checkbox"/> drug or alcohol dependency	<input type="checkbox"/> arthritis	<input type="checkbox"/> stomach ulcers
<input type="checkbox"/> kidney disease			<input type="checkbox"/> Emphysema
Are there any conditions or diseases not listed above that you have or have had? If you answered "yes" please list them: _____			
Do you smoke or chew tobacco?	<input type="checkbox"/> yes	<input type="checkbox"/> No	
For women only: Are you pregnant?	<input type="checkbox"/> yes	<input type="checkbox"/> No	
If so, what is the expected delivery date? _____			

GENERAL CONSENT STATEMENT

I hereby certify that I have read and understood and to the best of my knowledge accurately completed the above patient information form, dental and medical questionnaires. This information has been reviewed with me and have had the chance to ask questions and to receive answers regarding any medical or dental histories. I also give authorization to the dentist to do necessary diagnostic procedures and treatment under local anaesthetic as required to attain the best dental care. It is understood that I am financially responsible for the dental services I received from Dentistry on the "Q" dental providers even in the event that my insurance benefits do not cover the procedures rendered. I am aware that Dentistry on the "Q" has privacy code in which I can ask to see at any time I agree that Dentistry on the "Q" can collect, use and disclose personal information about me and all minors of whom I have joint or parental custody as set in your privacy policy.

Patient: _____ **Parent:** _____ **Guardian:** _____ **SIGNATURE:** _____
DATE _____