LORNE PARK DENTAL
ASSOCIATES

CONFIDENTIAL PATIENT INFORMATION

Date: ____

Salutation: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr.

Name: ____

Address: ____

City: ________________________ **Postal Code:** ______________

Home Telephone: ______________________________________

Business Telephone: ____________________________________

Cell: ____

Email: ____

Preferred Method of Contact: ____________________________

Employer: ____

Occupation: ____

Date of Birth: ____________/____________/____________
DAY *MONTH* *YEAR*

How did you hear about us? ______________________________
____

IN CASE OF EMERGENCY CONTACT:

Name: ____

Telephone: ____

Relation: ____

PHYSICIAN'S INFORMATION:

Physician's Name: ______________________________________

Physician's Phone: _____________________________________

Other Physicians: ______________________________________

OTHER DETAILS:

Are you being treated by other dental specialists? Y / N

Who? ____

Previous Dentist's Name: _________________________________

Previous Dentist's Phone: ________________________________

Do you have dental insurance?* Y / N
**If yes please complete insurance information sheet.*

Please turn page over to continue…

DENTAL HISTORY

Why are you here today? ____________________________

When was your last dental visit? ______________________

Is there anything about your teeth or smile that you would like to change? Y / N

If so, what?_______________________________________

Are any teeth sensitive to hot, cold, sweets, chewing? Y / N

Do your gums bleed? Y / N

Are there any growths or sore spots in your mouth? Y / N

Is breathing through your nose difficult? Y / N

Do you have difficulty chewing or problems with your bite? Y / N

Do you clench or grind day or night? Y / N

Do you wear a biteplane/nightguard? Y / N

Is it difficult to open your mouth as wide as you would like? Y / N

Does your jaw click when you chew or open wide? Y / N

Have you ever had an injury to your face or jaw? Y / N

Have you ever had periodontics (gum treatment) orthodontics (braces), root canal, oral surgery i.e. implants, wisdom teeth removal? Y / N

Have you ever had implant surgery to your jaw joints? Y / N

Do you play contact sports? Y / N

If so, do you wear a mouthguard when playing these sports? Y / N

Have you ever experienced an unpleasant reaction to dental anaesthetic (freezing) or any medications? Y / N

What do you use to clean your teeth? __________________

____

PRESENT STATE OF HEALTH

What are your main medical problems? _________________

____

What prescription/non-prescription drugs or herbal supplements are you taking? _________________________

____

____

Do you now or have you ever taken any osteoporosis medications? (eg. Fosamax or Actonel) Y / N

What medicines are you allergic to? __________________

____

What other allergies do you have? (eg. latex, seasonal, foods)

____

Have you ever experienced:

a) prolonged or abnormal bleeding? Y / N

b) fainting or dizzy spells? Y / N

c) chest pain/shortness of breath after mild exertion? Y / N

WOMEN

a) Do you take birth control pills? Y / N

b) Are you pregnant now? Y / N

c) If yes, what is your due date? ______________

PAST MEDICAL HISTORY

Have you been told you should be pre-medicated with antibiotics before dental treatment? Y / N

Have you been examined by your physician within the past year? Y / N

Have you ever taken steroids? Y / N

Do you now or have you ever used tobacco products? Y / N

Are you drug or alcohol dependent? Y / N

Have you ever been hospitalized, seriously ill or had any operations? Please explain ____________________ Y / N

____

Please check if you have had any of the following:

- ☐ Chest Pain/Angina
- ☐ Heart Attack
- ☐ Pacemaker or Defibrillator
- ☐ Other Heart Conditions
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Artificial Joints
- ☐ Metal Inserts
- ☐ Diabetes
- ☐ Low Blood Sugar
- ☐ Blood Disorders
- ☐ Blood Transfusion
- ☐ Thyroid Trouble
- ☐ Arthritis
- ☐ Lung Disease, COPD
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ G.I. Disease
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Lupus
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Sinus Trouble
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Severe Headaches
- ☐ Medic Alert Medallion
- ☐ Jewelry Allergy
- ☐ Sleep Apnea/CPAP

Any others? ___________________________________

Please place a mark on this line indicating the degree of anxiety you experience while receiving dental work.

NOT ANXIOUS AT ALL <----------------------------> GREATEST AMOUNT OF ANXIETY IMAGINABLE

I verify that the above information is accurate. I consent to the performing of dental procedures agreed upon, including the use of local anaesthetic as indicated. I will assume financial responsibility for fees associated with those procedures. I understand that Lorne Park Dental Associates requires 2 business days notice for any change in appointments or a fee may be charged.

Signature _________________________________

Date ______________/______________/______________

DAY *MONTH* *YEAR*