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AllardStationDental.com

PATIENT CHART NUMBER
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# NEW PATIENT FORM

The following information is required by our office to thoroughly diagnose any condition and give you personal attention. This form is **STRICTLY CONFIDENTIAL**. *Please fill out the form completely.*

## Personal Information

NAME		DATE OF BIRTH
ADDRESS		POSTAL CODE
HOME PHONE	CELL PHONE	EMAIL
OCCUPATION	EMPLOYER	WORK PHONE
HOW WOULD YOU LIKE TO BE CONTACTED? <i>(List in order, e.g. Cell, Work, Home, Email)</i>		PERSON RESPONSIBLE FOR YOUR ACCOUNT
IF CHILD, NAME OF MOTHER		IF CHILD, NAME OF FATHER

## Dental Insurance

NAME OF INSURANCE PLAN	I.D. # or CERTIFICATE #	POLICY HOLDER'S EMPLOYER	DENTAL PLAN HOLDER'S NAME
POLICY OR PLAN NUMBER	DEPENDENT NUMBER	COVERAGE A      B      C      Plan Max	PLAN HOLDER'S DATE OF BIRTH

## Medical History

PERSONAL PHYSICIAN	SPECIALIST
CLINIC LOCATION	PHONE #

## Do you have OR have you ever had *(Select all that apply)*

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> 1. hospitalization for illness or injury</li> <li>2. an allergic reaction to:             <ul style="list-style-type: none"> <li><input type="checkbox"/> aspirin, ibuprofen, acetaminophen</li> <li><input type="checkbox"/> penicillin</li> <li><input type="checkbox"/> erythromycin</li> <li><input type="checkbox"/> tetracycline</li> <li><input type="checkbox"/> codeine</li> <li><input type="checkbox"/> local anesthetic</li> <li><input type="checkbox"/> fluoride</li> <li><input type="checkbox"/> metals (gold, stainless steel)</li> <li><input type="checkbox"/> latex</li> <li><input type="checkbox"/> any other medications</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> 3. to take antibiotics prior to a dental procedure</li> <li><input type="checkbox"/> 4. heart problems / defect / pacemaker</li> <li><input type="checkbox"/> 5. heart murmur / ventricular prolapse</li> <li><input type="checkbox"/> 6. rheumatic fever / scarlet fever</li> <li><input type="checkbox"/> 7. high blood pressure</li> <li><input type="checkbox"/> 8. low blood pressure</li> <li><input type="checkbox"/> 9. a stroke</li> <li><input type="checkbox"/> 10. artificial prosthesis <i>(e.g. joints, stents, heart valve)</i> Date: _____</li> <li><input type="checkbox"/> 11. anemia or other blood disorder</li> <li><input type="checkbox"/> 12. abnormal bleeding</li> <li><input type="checkbox"/> 13. emphysema</li> <li><input type="checkbox"/> 14. tuberculosis</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> 15. asthma</li> <li><input type="checkbox"/> 16. breathing or sleep problems <i>(snoring, sinus, sleep apnea)</i></li> <li><input type="checkbox"/> 17. sinus problems</li> <li><input type="checkbox"/> 18. kidney disease</li> <li><input type="checkbox"/> 19. liver disease</li> <li><input type="checkbox"/> 20. jaundice</li> <li><input type="checkbox"/> 21. thyroid or parathyroid disease</li> <li><input type="checkbox"/> 22. hormone deficiency</li> <li><input type="checkbox"/> 23. high cholesterol</li> <li><input type="checkbox"/> 24. diabetes <i>(circle):</i> Type 1    Type 2</li> <li><input type="checkbox"/> 25. stomach or duodenal ulcer</li> <li><input type="checkbox"/> 26. digestive disorders (gastric reflux)</li> <li><input type="checkbox"/> 27. eating disorders (anorexia/bulimia)</li> </ul> |
|--|---|--|

**Do you have OR have you ever had (select all that apply)**

- 28. osteoporosis/osteopenia (taking bisphosphonates)
- 29. arthritis
- 30. glaucoma
- 31. contact lenses
- 32. head or neck injuries
- 33. epilepsy, convulsions (seizures)
- 34. neurologic problems / alzheimers / memory loss
- 35. viral infections and cold sores
- 36. any lumps or swelling in the mouth
- 37. dry mouth
- 38. hives, rash, hay fever
- 39. venereal disease
- 40. hepatitis (type\_\_\_\_\_)
- 41. HIV / AIDS
- 42. tumor, abnormal growth
- 43. radiation therapy
- 44. chemotherapy
- 45. emotional problems
- 46. psychiatric treatment
- 47. antidepressant medication
- 48. alcohol / drug dependency

**Are you: (Select all that apply)**

- 49. presently being treated for any other illness
- 50. aware of a change in your general health
- 51. often exhausted or fatigued
- 52. subject to frequent headaches
- 53. a smoker, smoked previously, use tobacco
- 54. Female – taking birth control pills
- 55. Female – pregnant /nursing
- 56. Male – prostate disorders

**Additional Medical Information**

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**List all medications, supplements, and/or vitamins taken within the last two years**

Medication	Reason for taking

**Describe any medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.**

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**Dental History**

REFERRED BY	PREVIOUS DENTIST	HOW LONG HAVE YOU BEEN A PATIENT?
DATE OF LAST DENTAL EXAM / CLEANING	DATE OF LAST DENTAL XRAYS	DATE OF LAST TREATMENT (eg. fillings, crowns, whitening)
<b>I ROUTINELY SEE MY DENTIST EVERY (Select one only)</b> <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> not routinely		<b>HOW OFTEN DO YOU:</b> BRUSH: _____ /day FLOSS: _____ /week BRUSH TONGUE: _____ /week
<b>HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? (Select one only)</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		

**WHAT IS YOUR IMMEDIATE DENTAL CONCERN? (Briefly describe)**

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**Dental History Details** (*Select all that apply*)

**Treatment History**

- Are you fearful of dental treatment?
- Have you had an unfavourable dental experience?
- Have you ever had complications from past dental treatment?
- Have you ever had trouble getting numb or reactions to local anesthetic?
- Did you ever wear braces, have orthodontic treatment or had your bite adjusted?
- Have you had any teeth removed?

**Smile Characteristics**

If you are not happy with the appearance and function of your teeth, what would you change?

- Whiter teeth
- Straighter teeth
- Close spaces
- Lengthen teeth
- Contour / reshape teeth
- Replace metal fillings
- Repair chipped / broken teeth
- Replace missing teeth
- Repair worn teeth
- Replace old crowns / caps that don't match

**Gum, Bone, and Tooth Structure**

- Are any teeth sensitive to hot, cold, biting, or sweets?
- Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?
- Do you feel or notice any holes (ie. Pitting) in your teeth?
- Have you ever been diagnosed or treated for periodontal (gum) disease?
- Have you ever experienced gum recession?
- Is there a history of periodontal disease in your family?
- Do your gums bleed when brushing, flossing, or eating?
- Are your teeth becoming loose?
- Have you ever noticed an unpleasant taste or odor in your mouth?
- Have you experienced a burning sensation in your mouth?

**Bite and Jaw**

- Do you have any problems chewing gum or hard foods?
- Have your teeth changed in the last 5 years, become shorter, thinner or worn?
- Are your teeth crowding or developing spaces?
- Do you have more than one bite or do you clench(squeeze) your teeth to make them fit together?
- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
- Do you have tension headaches or sore teeth?
- Do you wear or have you ever worn a bite appliance? (night guard)

I hereby certify that the information given here is complete, true and correctly recorded, and I consent to examination and treatment agreed to be necessary or advisable.

\_\_\_\_\_  
Signature of Patient (or Parent / Guardian)

\_\_\_\_\_  
Date

*Please submit this form to our staff at your earliest convenience*