Sherwood Park
DENTAL CARE CENTRE

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PATIENT CHART NUMBER

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? (*List in order, e.g. Cell, Work, Home, Email*)	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*)

Ⓢ 1. hospitalization for illness or injury

2. an allergic reaction to:
   - Ⓢ aspirin, ibuprofen, acetaminophen
   - Ⓢ penicillin
   - Ⓢ erythromycin
   - Ⓢ tetracycline
   - Ⓢ codeine
   - Ⓢ local anesthetic
   - Ⓢ fluoride
   - Ⓢ metals (gold, stainless steel)
   - Ⓢ latex
   - Ⓢ any other medications

   _____

Ⓢ 3. to take antibiotics prior to a dental procedure

Ⓢ 4. heart problems / defect / pacemaker

Ⓢ 5. heart murmur / ventricular prolapse

Ⓢ 6. rheumatic fever / scarlet fever

Ⓢ 7. high blood pressure

Ⓢ 8. low blood pressure

Ⓢ 9. a stroke

Ⓢ 10. artificial prosthesis *(e.g. joints, stents, heart valve)* Date: _____

Ⓢ 11. anemia or other blood disorder

Ⓢ 12. abnormal bleeding

Ⓢ 13. emphysema

Ⓢ 14. tuberculosis

Ⓢ 15. asthma

Ⓢ 16. breathing or sleep problems *(snoring, sinus, sleep apnea)*

Ⓢ 17. sinus problems

Ⓢ 18. kidney disease

Ⓢ 19. liver disease

Ⓢ 20. jaundice

Ⓢ 21. thyroid or parathyroid disease

Ⓢ 22. hormone deficiency

Ⓢ 23. high cholesterol

Ⓢ 24. diabetes (*circle*): Type 1 Type 2

Ⓢ 25. stomach or duodenal ulcer

Ⓢ 26. digestive disorders (gastric reflux)

Ⓢ 27. eating disorders (anorexia/bulimia)

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

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

Are you: (*Select all that apply*)

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

Additional Medical Information

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.

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)*

I ROUTINELY SEE MY DENTIST EVERY *(Select one only)*

⑤ 3 months ⑤ 4 months ⑤ 6 months ⑤ 12 months ⑤ not routinely

HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? *(Select one only)*

⑤ Excellent ⑤ Good ⑤ Fair ⑤ Poor

HOW OFTEN DO YOU:

BRUSH: _____/day

FLOSS: _____/week

BRUSH TONGUE: _____/week

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

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