NEW PATIENT HEALTH HISTORY FORM

Please spend a few minutes completing this New Patient Health History Form. Once completed, please give form to the receptionist.

Title: \_\_\_\_\_\_\_ Given Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender: \_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Contact Method: \_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emerg. Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emerg. Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you available for Short Notice Appointments: Yes/ No

DENTAL INFORMATION

In the following section, please select whichever applies. Your answers are for our records only and will be kept confidential. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Do your gums bleed when brushing or flossing? | Yes  No | Does food frequently get caught in your teeth? | | Yes  No | | Have you ever had Orthodontic Treatment (braces)? | Yes  No | Do you bite your lip or cheeks frequently? | | Yes  No | | Are your teeth sensitive to cold/hot/sweets/pressure? | Yes  No | Do you have headaches or migraines? | | Yes  No | | Do you feel pain to any of your teeth? | Yes  No | Have you had any difficult extractions in the past? | | Yes  No | | Do you have any sores or lumps in your mouth? | Yes  No | Ever worn a nightguard or other appliance? | | Yes  No | | Have you ever had a head/neck/jaw injury? | Yes  No | Have you ever had difficulty opening or closing your jaw? | | Yes  No | | Do you have any loose teeth? | Yes  No | Have you had Periodontal Treatment? (gums) | | Yes  No | | If you have any current dental problem, please describe: | | | Please give a brief description of your oral hygiene habits: | | | | Do you have any other concerns about having dental treatment? If so, please explain: Yes  No | | | Do you feel nervous about visiting the dentist? Yes  No  If so, please explain | | | | Are you happy with the appearance of your teeth? If not, please explain. Yes  No | | | Please enter your previous dentist’s name and location: | | |  |  |  |  | | --- | --- | --- | | Date of your last teeth cleaning: | Date of your last dental check up: | Date of your last check up X rays: | | What can we do to make you smile? Check all that apply and we’ll get back to you with more information about your inquiry | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Veneers  Gummy Smile  Dentures | Broken/Cracked Teeth  Replace Metal Fillings  Replace Missing Teeth | White Fillings  Eliminate Gaps  Dental Implants | One Hour In-Office Whitening  Invisalign Teeth Straightening  Rejuvenate Worn/Stained | Sleep Apnea/ Snoring  Nitrous Sedation  Broken/Cracked Teeth | | | | |  |

MEDICAL INFORMATION

Dental professionals primarily treat the area in and around your mouth, but since your mouth is part of your body, any medication you are taking and your health history have a important relationship with your dental treatment. Please answer the following questions:

Are you currently seeing a Family Physician? If so, please enter their name, and the date of your last visit: Yes No

Have you recently (in the last 2 years) been hospitalized or had any major operation? Yes  No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a serious head or neck injury? Yes  No

If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Females only: Are you or could you be pregnant? Yes  No  If yes, what is the expected delivery date? \_\_\_\_\_\_\_\_\_\_

**Please go over the following section and indicate by circling which of the following you have or have had.**

|  |  |  |  |
| --- | --- | --- | --- |
| Aids/ HIV positive | Chest Pains | Hemophilia | Cancer |
| Alzheimer’s Disease | Circulation problems | Hepatitis A | Chemotherapy |
| Anaphylaxis | Diabetes | Hepatitis B or C | Low Blood Pressure |
| Anemia | Emphysema | High Blood Pressure | Tuberculosis |
| Arthritis / Gout | Epilepsy/ Seizures | Kidney Problems | Depression |
| Artificial Heart Valve | Fainting | Liver Disease | Osteoporosis |
| Artificial Joint | Glaucoma | Lung Disease | High Cholesterol |
| Asthma | Head or Neck Injuries | Mental/ Nervous Disorder | Acid Reflux |
| Blood Disease | Heart Attack/ Failure | Organ/ Medical Transplant | Herpes/Cold Sores |
| Bruises Easily | Heart Murmur/Heart Stent/ Heart Surgery | Sickle Cell disorder | Severe Headaches |
| Thyroid Problems | Heart Pacemaker | Stroke | Scarlet Fever |

Please enter details or any further information:

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Please list any prescription or non-prescription medicine you are currently taking or have recently taken.

|  |  |
| --- | --- |
|  | |
| **Have you ever been advised to take antibiotics before dental treatment?** Yes  No  Do you currently smoke? Yes  No  If yes, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you use marijuana in any form or recreational drugs?  Yes  No | Are you allergic to OR have you had a reaction to any of the following?   |  |  | | --- | --- | | Antibiotics | Yes  No | | Nitrous Oxide | Yes  No | | Aspirin | Yes  No | | Codeine | Yes  No | | Local Anaesthetic | Yes  No | | Other: |  | |

Insurance Information

|  |  |
| --- | --- |
| **Primary insurance** | **Secondary insurance** |
| Subscriber name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber DOB (DD/MM/YYYY): (\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_) | Subscriber name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber DOB (DD/MM/YYYY): (\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_) |

This is to certify that I consent to the performing of dental procedures agree to be necessary including the use of local anesthetics as indicated. I will assume responsibility for fees associated with those procedures. I am aware that a $50.00 charge will be applied to my account for missed or cancelled appointments of less than 24 hours of 1 business day notice.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_