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.

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	☐ Broken/Cracked Teeth	☐ White Fillings	☐ One Hour In-Office Whitening	☐ Sleep Apnea/ Snoring
☐ Gummy Smile	☐ Replace Metal Fillings	☐ Eliminate Gaps	☐ Invisalign Teeth Straightening	☐ Nitrous Sedation
☐ Dentures	☐ Replace Missing Teeth	☐ Dental Implants	☐ Rejuvenate Worn/Stained	☐ 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:

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: _____	Subscriber name:_____
Relationship:_____	Relationship:_____
Insurance Name: _____	Insurance Name: _____
Policy #:_____Subscriber ID: _____	Policy #:_____Subscriber ID: _____
Subscriber Employer: _____	Subscriber Employer: _____
Subscriber DOB (DD/MM/YYYY): (_____/_____/_____)	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: _____