DENTIST Dr John Miller Dr Sam Goodman

Preventive | Cosmetic | Therapeutic

Medical History Questionnaire

NAME: ☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr ☐X

Last

First Middle

Date of Birth (dd/mm/yyyy)

ADDRESS:

Street

City Prov Postal Code

PHONE:

Home Cell Business

PLACE OF EMPLOYMENT / OCCUPATION:

How would you like us to contact you?

☐Phone ☐Text Message ☐Email:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name:

Relationship: Phone:

FAMILY DOCTOR:

Name:

Phone:

(i) MEDICAL SPECIALIST:

Name:

Specialty: Phone:

(ii) MEDICAL SPECIALIST:

Name:

Specialty: Phone

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
☐YES ☐NO ☐NOT SURE / MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
☐YES ☐NO ☐NOT SURE / MAYBE

4. Are you taking any medications, non-prescription drugs, herbal supplements or vitamins of any kind?
☐YES ☐NO ☐NOT SURE / MAYBE

5. Do you have any allergies? If yes, please list using categories below.
☐YES ☐NO ☐NOT SURE / MAYBE

   ☐ MEDICATIONS _____

   ☐ LATEX/RUBBER PRODUCTS _____

   ☐ OTHER (i.e. HAY FEVER, FOODS) _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐YES ☐NO ☐NOT SURE / MAYBE

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7. Do you have, or have you ever had asthma?
☐YES ☐NO ☐NOT SURE/MAYBE

8. Do you have, or have you ever had any heart or blood pressure problems?
☐YES ☐NO ☐NOT SURE/MAYBE

9. Do you have a prosthetic or artificial joint? If yes, when was the last surgery date?
☐YES ☐NO ☐NOT SURE/MAYBE

10. Have you ever been advised by your doctor to take antibiotics before dental treatment?
☐YES ☐NO ☐NOT SURE/MAYBE

11. Do you have any conditions or are you undergoing any treatments or therapies that could affect your immune system (i.e. leukemia, HIV/AIDS, radiotherapy, chemotherapy)?
☐YES ☐NO ☐NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease?
☐YES ☐NO ☐NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder?
☐YES ☐NO ☐NOT SURE/MAYBE

14. Do you take blood thinners?
☐YES ☐NO ☐NOT SURE/MAYBE
Name: Dose: INR:

15. Have you ever been hospitalized for any illness or operations? If yes, please explain.
☐YES ☐NO ☐NOT SURE/MAYBE

16. Do you have, or have you ever had any of the following? Please check all that apply.

☐chest pain, angina	☐heart attack	☐drug/alcohol	☐kidney disease	☐prosthetic heart valve
☐seizures (epilepsy)	☐shortness of breath	dependency	☐thyroid disease	☐arthritis
☐lung disease	☐diabetes	☐pacemaker	☐diet pill therapy	☐cancer
☐tuberculosis	☐stomach ulcers	☐stroke	☐steroid therapy	

17. Are there any conditions or diseases not listed that you have or have had? If so, what?
☐YES ☐NO ☐NOT SURE/MAYBE

18. Are there any diseases or medical problems that run in your family? (i.e. diabetes, cancer or heart disease)?
☐YES ☐NO ☐NOT SURE/MAYBE

19. Are you nervous during dental treatment?
☐YES ☐NO ☐NOT SURE/MAYBE

20. For women only: Are you breast feeding or pregnant? If pregnant, what is your expected delivery date?
☐YES ☐NO ☐NOT SURE/MAYBE

21. Blood Pressure Pulse Rate Initial

To the best of my knowledge the above information is correct:

Patient/Parent/Guardian Signature Date

Dentist Signature Date

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DENTAL HISTORY QUESTIONNAIRE

Date: _____

Name: _____

1. Is there a dental problem that you would like treated immediately? _____

   _____

2. Date of your last dental visit _____ Reason _____

3. Date of last dental scaling? _____

4. Last Dental x-rays taken? _____

5. How often do you brush your teeth? _____

6. Do you use mouth rinse? ☐ YES ☐ NO What brand? _____

7. How often do you floss? _____

8. Do you use a manual ☐ or power ☐ toothbrush? What brand? _____

9. Do you use any other dental aids (proxabrush, stimudents,etc.)? ☐ YES ☐ NO

   Name of dental aid: _____ How often? _____

10. Do you smoke? ☐ YES ☐ NO How many per day? _____ How many years? _____

11. Are you interested in quitting? ☐ YES ☐ NO

12. Have you ever had any of the following treatments?

Periodontal treatment (treatment to your gums)	☐ YES ☐ NO ☐ SURGERY ☐ GRAFTING
Orthodontics (braces)	☐ YES ☐ NO
Oral surgery (wisdom teeth extractions, etc.)	☐ YES ☐ NO
Root canal treatments	☐ YES ☐ NO

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13. Are any of your teeth sensitive to: ☐ HOT ☐ COLD ☐ SWEETS ☐ BITING

If yes: Which teeth and how long have they been sensitive?

_____

14. Do you ☐ clench or ☐ grind your teeth while sleeping or awake? ☐ YES ☐ NO

If yes: Do you currently wear a bite guard? ☐ YES ☐ NO

or have you in the past? ☐ YES ☐ NO

15. Do you have any growths or sores in your mouth? ☐ YES ☐ NO

If yes: Where and how long has it been present? _____

16. Do you get cold sores and/or canker sores? ☐ YES ☐ NO

If yes: How often? _____

17. Do you experience pain in your jaw joints? ☐ YES ☐ NO

18. Do you get headaches? ☐ YES ☐ NO If yes, how often? _____

19. Do you wear dentures? ☐ YES ☐ NO

If yes: Are you happy with the way they fit? ☐ YES ☐ NO

How do you clean your dentures? _____

21. Are you happy with your smile? ☐ YES ☐ NO

22. Would you like to improve your smile? ☐ YES ☐ NO

23. Are you interested having straighter teeth without wearing braces? ☐ YES ☐ NO

24. Is there anything else you would like us to know?

_____

_____

Signature: _____ Date: _____

INSURANCE INFORMATION

PRIMARY

NAME OF INSURED

☐Mr ☐Ms ☐Miss ☐Mrs ☐Dr ☐X

Last First First Middle

Birth Date:

ADDRESS

Street City Prov Postal Code

Employer Name

ADDRESS

Street City Prov Postal Code

Insurance Plan Name and Address:

Insurance ID# Group #

SECONDARY

NAME OF INSURED

Last First Middle

Birth Date:

ADDRESS

Street City Prov Postal Code

Employer Name

ADDRESS

Street City Prov Postal Code

Patient's relationship to insured:

☐Self ☐Spouse ☐ Child ☐ Other

Insurance Plan Name and Address

ID# Group #

CONSENT FOR SERVICES (insured/non insured)

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I authorize release; to my dental benefits plan administrator and CDA, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revoked the same.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient/parent/guardian	Date:	Relationship to Patient

Signature of patient/parent/guardian	Date:	Relationship to Patient

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RESCHEDULING POLICY

WE TRY OUR VERY BEST TO OFFER YOU APPOINTMENTS THAT ACCOMMODATE YOUR SCHEDULES. THIS TIME IS RESERVED JUST FOR YOU. IN ORDER TO GIVE YOU THE BEST CARE POSSIBLE AND TO BE FAIR TO ALL OUR PATIENTS, WE ASK THAT YOU MAKE EVERY EFFORT TO KEEP THESE APPOINTMENTS.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, WE ASK THAT YOU GIVE US AT LEAST TWO BUSINESS DAYS NOTIFICATION.

FAILURE TO NOTIFY US MAY RESULT IN A RESCHEDULING FEE OF $50.00 OR GREATER. THIS FEE MUST BE PAID PRIOR TO STARTING ANY FURTHER TREATMENT.

THANK YOU FOR YOUR COOPERATION.

_____ _____

SIGNATURE DATE

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FINANCIAL AGREEMENT

PAYMENT ARRANGEMENTS FOR ALL DENTAL WORK ARE TO BE MADE AT THE TIME OF YOUR DENTAL TREATMENT. WE DO NOT ACCEPT PAYMENT FROM THE INSURANCE COMPANIES.

WE OFFER THE FOLLOWING PAYMENT OPTIONS:

- VISA
- MATERCARD
- INTERAC
- CASH

KEEP IN MIND, IF YOU HAVE DENTAL INSURANCE AND OUR OFFICE CAN SUBMIT YOUR CLAIM ELECTRONICALLY, YOU SHOULD RECEIVE YOUR CHEQUE FROM INSURANCE COMPANY WITHIN 2-7 DAYS.

FINANCING OPTIONS ARE AVAILABLE FOR ALL TREATMENTS: PLEASE ASK ANY OF OUR TEAM MEMBERS TO ASSIST WITH MAKING ARRANGEMENTS.

***PLEASE NOTE WE DO NOT ACCEPT PERSONAL CHEQUES

_____ _____

SIGNATURE DATE

OFFICE POLICY FOR THE COLLECTION, USE AND DISCLOSURE OF PATIENT PERSONAL INFORMATION

As dental professionals we are required to comply with Federal and Provincial Privacy Legislation, (PIPEDA) and (PHIPA). In order to do so, each of our patients are requested to sign a consent form acknowledging and allowing us to collect, use and disclose personal information according to specific guidelines.

OFFICE POLICY FOR THE COLLECTION, USE AND DISCLOSURE OF PATIENT PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality dental care. We understand the importance of protecting your privacy, and we are committed to collecting, using and disclosing your personal information responsibly.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Our office has a Privacy Code, which you may review at any time, and freely discuss with our Privacy Information Officer (federal) also known as our Health Information Custodian (provincial). In our office we will collect, use and disclose information about you for the following purposes:

- to assess your health needs and risks, and to provide safe and efficient dental care
- to enable us to contact you, to schedule and confirm appointments, including following up for treatment
- to offer and to provide treatment, care and services in relationship to the mouth and jaws and dental care generally to communicate with other treating health-care providers, including other specialists and general dentists, and/or referring dentists, physicians, pharmacists, and laboratory technicians
- to allow us to efficiently manage your account, including invoicing for goods and services, obtaining debit and credit card payments, credit authorization purposes, and for collection of unpaid accounts
- to complete and prepare dental treatment estimates/claims for third party adjudication to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act

- to permit potential purchasers, practice brokers or legal and financial advisors to evaluate the dental practice
- to provide your information and records to the dentist's insurance carrier if required
- for teaching and demonstrating purposes on an anonymous basis
- to assist this office to comply with all regulatory requirements and comply generally with the law.

Patient Acknowledgement and Consent

I have reviewed the above information that explains why and how your office will collect, use and disclose my/my child's personal information, and have been given the opportunity to ask questions about the steps your office is taking to protect this information.

I acknowledge and agree that the office of

Dr. _____

can collect, use and disclose personal information about me /my child for the purposes listed.

_____	_____	_____
Patient	Patient Signature	Date
_____	_____	_____
Witness	Witness Signature	Date