

DATE: \_\_\_\_\_

## PATIENT INFORMATION

NAME: \_\_\_\_\_

(first)

(last)

(middle initial)

PREFERRED NAME: \_\_\_\_\_

DATE OF BIRTH (DD/MM/YYYY): \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

PO BOX (if applicable): \_\_\_\_\_

CITY: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CELLULAR PHONE: \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

SEX AT BIRTH:  Male  Female

MARITAL STATUS:  Single  Married

Common Law  Widowed  N/A (Minor)

## IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

HEALTH CARD NUMBER: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_

**Do you have Dental Insurance Benefits?** Yes  No

Policy Number: \_\_\_\_\_

ID Number: \_\_\_\_\_

## PATIENT DENTAL HISTORY

Reason for today's visit: \_\_\_\_\_

### Place a mark on all of the following conditions that apply:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bad Breath                 | <input type="checkbox"/> Food traps in teeth    | <input type="checkbox"/> Pain around ear         |
| <input type="checkbox"/> Bleeding gums              | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Pain when brushing      |
| <input type="checkbox"/> Blisters or sores in mouth | <input type="checkbox"/> Head/Neck Injury       | <input type="checkbox"/> Periodontal treatment   |
| <input type="checkbox"/> Clenching/Grinding         | <input type="checkbox"/> Jaw pain or tiredness  | <input type="checkbox"/> Sensitivity to hot/cold |
| <input type="checkbox"/> Clicking or Popping jaw    | <input type="checkbox"/> Lip or cheek biting    | <input type="checkbox"/> Sensitivity on biting   |
| <input type="checkbox"/> Dry Mouth                  | <input type="checkbox"/> Loose Teeth            | <input type="checkbox"/> Snoring                 |
| <input type="checkbox"/> Fingernail biting          | <input type="checkbox"/> Orthodontic treatment  | <input type="checkbox"/> Sleep Apnea             |

Do you have a dental concern that is not listed above? \_\_\_\_\_

Do you have any prosthetic tooth replacements (Dentures, Partial, Crowns, Implants, etc.?) Yes  No

**Do you have any known allergies?** Yes No

If so please list: \_\_\_\_\_

Are you allergic to any of the following:  Latex  Penicillin  Codeine  Aspirin

Do you smoke /use tobacco/marijuana products? Yes No

If so, How many per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you consume alcohol? Yes No

If so, How many drinks do you consume per month? \_\_\_\_\_

Do you consume coffee or tea? Yes No If so, How many per day? \_\_\_\_\_

### MEDICAL HISTORY QUESTIONNAIRE

**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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.**

**Place a mark on all of the following conditions that apply:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Organ Transplant        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Osteoporosis            |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Headaches/Migraines      | <input type="checkbox"/> Pacemaker               |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Psychiatric Care        |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Radiation Treatment     |
| <input type="checkbox"/> Chemotherapy       | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Respiratory Disease     |
| <input type="checkbox"/> Cold Sores         | <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Rheumatoid Arthritis    |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Sinus Trouble/Sinusitis |
| <input type="checkbox"/> Drug Dependency    | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Ulcers                  |
|   |   | <input type="checkbox"/> Venereal Disease        |

Women:  Yes  No If Pregnant, how far along are you currently?

Are you on Birth Control?  Yes  No

Are you Pregnant?  Yes  No

Are you Nursing?  Yes  No \_\_\_\_\_

Do you have any other medical conditions not listed above? If so, please disclose below:  Yes  No

Have you had any recent surgeries or major surgery in the past? If so, please disclose below:  Yes  No

Are you taking any medications, non-prescription drugs, natural supplements of any kind?  Yes  No

### Medication/Dosage

### Reason for medication

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I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made payment is due at each office visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist.

***I am aware that 24 hours notice is required to change or cancel an appointment without charge.***

X \_\_\_\_\_  
Signature, (parent or guardian if under 18 years old)

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

Please turn over the page to continue



**Dear Valued Patient,**

Thank you for trusting us to look after your oral health care needs. We consider it a privilege to care for you and we always work hard to maintain your trust and confidence. Part of maintaining your trust means ensuring you know about our practice and how we utilize and safeguard your personal health information.

*A little bit about our practice*

At Elmwood Dental Clinic we are committed to ensuring a professional, safe, and trusted office environment. All clinical dentistry services are performed by dental professionals in good standing with Provincial Dental Board of Nova Scotia and all clinical hygiene services are performed by registrants in good standing with the College of Dental Hygienists of Nova Scotia. To provide you with optimized oral health care and excellent service we use, store, and analyze certain personal health information that we (a) collect from you, (b) generate through diagnostic testing and treatment planning, or (c) receive from your other health care providers.

We will not collect, disclose, or use any of your information without your knowledge or consent. Only persons with a clinical (or related administrative) need to know a piece of information will be granted access to that information. In the same vein we embrace the principle that only the necessary amount of information shall be disclosed for any task or function. Our staff are trained on the importance of keeping your information safe, secure, and confidential.

Our designated privacy officer can be reached at [privacy.officer@dentalcorp.ca](mailto:privacy.officer@dentalcorp.ca) should you have any questions or concerns. We appreciate your feedback.

Below you will find our office's privacy policy. By signing, you acknowledge that you have read and understood the information provided in the policy and that you consent to the practices it describes. Feel free to ask us any questions you might have.

***Thank you very much for the privilege of assisting you with your oral health care needs. We look forward to caring for your smile.***

**Patient Name:** \_\_\_\_\_

**Patient (Guardian) Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_