

MINA FAMILY DENTISTRY

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

Email:

DENTAL HISTORY

Please share the following dates:

Date of last dental visit: _____

Date of last dental x-rays: _____

Do you smoke or use chewing tobacco? Yes No

If yes, how often? _____ For how long? _____

2. Please check any of the following problems that may apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Sensitivity (hot, cold and/or sweet) | <input type="checkbox"/> Headaches, earaches or neck pain |
| <input type="checkbox"/> Tooth pain or discomfort while chewing | <input type="checkbox"/> Grinding or clenching teeth |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Jaw joint pain (clicking/cracking) |
| <input type="checkbox"/> Broken teeth or fillings | <input type="checkbox"/> Bad breath or bad taste in your mouth |
| <input type="checkbox"/> Loose, tipped or shifting teeth | <input type="checkbox"/> Sore spots/growths |

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 currently being treated for any medical condition or have you been treated within the past year? If yes, please explain?

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 or herbal supplements of any kind? If yes, please list them.

Yes No Not sure/Maybe

5. Do you have any allergies? If yes, please list them using the categories below:

Yes No Not sure/Maybe

a) medications

b) latex/rubber products

c) other (e.g. hay fever, seasonal/environmental, 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

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 or have you ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?

Yes No Not sure/Maybe

10. Do you have a prosthetic or artificial joint?

Yes No Not sure/Maybe

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, 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. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.

Yes

No

Not sure/Maybe

15. Do you have or have you ever had any of the following? Please check.

chest pain, angina

rheumatic fever

pacemaker

steroid therapy

seizures (epilepsy)

heart attack

mitral valve prolapse

lung disease

diabetes

kidney disease

stroke, TIA

tuberculosis

stomach ulcers

thyroid disease

shortness of breath

heart murmur

cancer

arthritis

drug/alcohol/cannabis
use or dependency

osteoporosis
medications
(e.g. Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.

Yes

No

Not sure/Maybe

17. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)?

Yes

No

Not sure/Maybe

18. Do you smoke or chew tobacco products?

Yes

No

Not sure/Maybe

19. Are you nervous during dental treatment?

Yes

No

Not sure/Maybe

20. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

Yes

No

Not sure/Maybe

21. Do you identify as a patient with a disability? If yes, please explain.

Yes

No

Not sure/Maybe

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

Patient/Parent/Guardian Signature:

Date:

Dentist Signature:

Date: