ROTHWELL
DENTAL CENTRE DENTAIRE

Today's date ___/___/___ MM/ DD /YYYY

Date of birth ___/___/___ MM/ DD /YYYY

PID [ ] *For office use only*

All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form. PLEASE PRINT.

PERSONAL INFORMATION

Gender identity _____ Pronoun used _____

Last name, First name _____

Address _____
Number Street City Province Postal Code

Phone # ( ) _____ ☐ Home ☐ Business ☐ Cell

Email address _____

Preferred contact method ☐ Phone call ☐ Text ☐ Email

Family physician _____ Previous dentist _____

Whom may we thank for referring you? _____

Are there other family members patients here? ☐ Yes

Name(s) _____

MEDICAL HISTORY

Indicate which of the following you presently have or have had:

☐ Anemia	☐ Fainting/dizzy spells	☐ Migraine headaches
☐ Angina	☐ Healing complications	☐ Organ transplant
☐ Arthritis	☐ Heart condition (i.e. murmur, pacemaker)	☐ Osteoporosis
☐ Asthma	☐ Hemorrhage	☐ Psychiatric treatment
☐ Blood disorder	☐ HIV or AIDS	☐ Rheumatic fever
☐ Bronchitis	☐ Hodgkin's disease	☐ Scarlet fever
☐ Cancer	☐ Hypertension (high blood pressure)	☐ Sexually transmitted disease (STD)
☐ Diabetes (Type 1)	☐ Hypotension (low blood pressure)	☐ Sinus trouble
☐ Diabetes (Type 2)	☐ Kidney disease	☐ Skin disease
☐ Drug or alcohol dependency	☐ Liver disease (i.e. hepatitis, cirrhosis)	☐ Stomach ulcer
☐ Eating disorder	☐ Lung disease	☐ Stroke
☐ Emphysema	☐ Lupus	☐ Thyroid problem
☐ Epilepsy	☐ Malignant hyperthermia	☐ Tuberculosis
☐ Eye problem (i.e. glaucoma, cataract)	☐ Mental/nervous disorder	☐ Other(s) [ ]

	Yes	No
Are you currently under the care of a physician?	☐	☐
Are you taking any medications, vitamins, natural products or non-prescription drugs?.....	☐	☐
If yes, please list: [ ]		
Have you experienced an allergic/adverse reaction to any medication (including dental anesthetic)?	☐	☐
If yes, please specify: [ ]		
Do you have any food, latex or metal allergies?	☐	☐
Have you been hospitalized in the last 5 years?	☐	☐

	Yes	No
Do you have artificial joints (knee, hip, etc.)?	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐
Have you gained/lost a significant amount of weight during the last year or so?	☐	☐
Have you ever had radiotherapy and/or chemotherapy treatments (tumor)?	☐	☐
Do you smoke, vape or use any other forms of tobacco?	☐	☐
Do you use drugs or other substances for recreational purposes?	☐	☐
Are you pregnant or suspect you may be?	☐	☐
Are you taking any birth control pills?	☐	☐

Follow-up/Additional information: _____

_____

DENTAL HISTORY

When was your last dental visit? _____ Last x-ray? _____

How often do you brush your teeth? _____ ☐ Manual ☐ Electric

How often do you floss your teeth? _____

	Yes	No
Have you been seeing a dentist regularly?	☐	☐
Is there a dental problem you would like treated immediately?	☐	☐
Do any of your teeth ache?	☐	☐
Are you being followed by a dental specialist?	☐	☐
Would you like to improve your smile or the appearance of your teeth?	☐	☐
Have you previously had an orthodontic treatment?	☐	☐
Do your gums bleed when you brush?	☐	☐
Does food catch between your teeth?	☐	☐
Do you feel you have bad breath at times (halitosis)?	☐	☐
Do you suffer from xerostomia (dry mouth)?	☐	☐
Do you have a family history of oral cancer?	☐	☐
Do you experience any pain/problems chewing your food?	☐	☐
Does your jaw make sounds/noises while opening/closing/chewing?	☐	☐
Have you ever experienced any blows to your jaw?	☐	☐
Do you grind or clench your teeth during the day or night?	☐	☐
Do you wear a nightguard?	☐	☐
Do you snore or suffer from sleep apnea?	☐	☐
Have you ever had any complications during or following treatment?	☐	☐
Does it make you nervous or uneasy to receive dental treatment?	☐	☐
Have you ever had an upsetting experience in a dental office?	☐	☐

Follow-up/Additional information: _____

_____

OFFICE POLICY: In the event of a cancellation with less than 48 hours' notice, a fee will be charged.

PATIENT RELEASE: I, the undersigned, hereby declare that I have read, understood and answered the above questionnaire to the best of my knowledge. I also promise to inform you of any change to my health.

_____ _____

Date (MM/DD/YYYY) Signature (Patient or Guardian)