

Patient Information

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PERFERED NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY/PROV\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSTAL\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AHC #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON TO CONTACT IN EMERGANCY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW WERE YOU REFERRED TO OUR OFFICE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*\*\* refer a friend and receive $50 gift card

 \*\*\* write a GOOGLE review and you’re entered into a continuous monthly drawing

 CONSENT

\*I GIVE CONSENT TO SUBMIT MY DENTAL INSURANCE ON MY BEHALF, PAYABLE TO DOWNTOWN CORE DENTAL

\*I UNDRESTAND THAT I AM REPSONSABLE FOR ANY OUTSTANDING FEES OUTSIDE OF MY INSURANCE PLAN COVERAGE, WHICH IS PAYABLE IMMEDIATELY UPON COMPLETION OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

\*I UNDERSTAND THAT MY INSURANCE IS A RELATIONSHIP BETWEEN MYSELF, MY EMPLOYER AND THE INSURANCE COMPANY, THAT VARIES FROM ONE PLAN TO ANOTHER

\*I UNDERSTAND THAT DOWNTOWN CORE DENTAL MAY GIVE AN ESTIMATE ON MY DENTAL COVERAGE, HOWEVER IT IS ONLY AN ESTIMATE THAT IS SUBJECT TO CHANGE DEPENDING ON TREATMENT AND INSURANCE COVERAGE. THAT AS A CARRIER OF COVERAGE, IT IS MY RESPONSIBLTY TO BE AWARE OF PLANS BENEFITS, MAXIMUMS, LIMITATIONS, EXCLUSIONS, WAITING PERIODS, ETC

\*I GIVE DOWNTOWN CORE DENTAL THE RIGHT TO RELEASE ANY INFORMATION TO MY HEALTH, SUCH AS MEDICAL HISTIRY, XRAYS, RELEVANT TREATMENT, INSURANCE, PHYSICIANS, DENTAL SPECIALISTS THAT I MAY BE REFERRED TO

\*I UNDERSTAND DOWNTOWN CORE DENTAL WILL GIVE A COMPLIMENTARY REMINDER OF UPCOMING APPOINTMENTS, AND HAS AN 48 HOUR BUSINESS DAY CANCELLATION POLICY, THAT IS SUBJECT TO A $50 PER HOUR FEE. THIS FEE WILL BE PAYABLE BEFORE ANY FURTHER APPOINTMENTS CAN BE MADE

WE REQUIRE A CREDIT CARD ON FILE FOR ANY TREATMENT THAT IS NOT ADJUDICATED BY YOUR DENTAL INSURANCE AFTER DENTAL TREATMENT RENDERED

ANY AMOUNT UNDER $200 WILL BE SUBMITTED AFTER YOUR DENTAL INSURANCE HAS MADE PAYMENT. OVER $200 YOU WILL RECEIVE A COURTSEY CALL TO PAY BY ALTERNATE METHODS. IF NO THERE IS NO ANSWER OR RETURN CALL/EMAIL, YOUR CREDIT CARD WILL BE CHARGED FOR THE FULL BALANCE OWING, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

CREDIT CARD NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXPIRATION\_\_\_\_\_\_\_\_\_\_\_\_CVC\_\_\_\_\_\_\_\_

CONSENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Previous Dentist How long had you been a patient? Months/Years

Date of most recent dental exam Date of most recent x-rays

Date of most recent treatment (other than a cleaning) I routinely see my dentist every: *☐*3 mo *☐*6 mo *☐*12 mo

How would you rate the condition of your mouth? *☐*Excellent *☐*Good *☐*Fair *☐*Poor

**WHAT IS YOUR IMMEDIATE CONCERN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

Physician and their specialty (if applicable) Office Phone

Most RECENT physical examination Purpose

What is your estimate of your general health? *☐*Excellent *☐*Good *☐*Fair *☐*Poor

**DO YOU OR HAVE YOU EVER HAD: YES NO YES NO**

1. Hospitalization for illness or injury *Y N* 27. Stomach or duodenal ulcer *Y N*

2. An allergic or bad reaction to any of the following *Y N* 28. Digestive/eating disorder (e.g., celiac disease,

3. Heart problems/cardiac stent in the last 6 months *Y N*  gastric reflux, bulimia, anorexia) *Y N*

4. History of infective endocarditis *Y N* 29. Osteoporosis/osteopenia (taking

5. Artificial heart valve, repaired heart defect (PFO) *Y N*  bisphosphonates) *Y N* 6. Pacemaker or implantable defibrillator *Y N* 30. Arthritis *Y N*

7. Orthopedic implant (joint replacement) *Y N* 31. Autoimmune disease (i.e. rheumatoid 8. Rheumatic or scarlet fever *Y N*  arthritis, lupus, scleroderma) *Y N*

9. High or low blood pressure *Y N* 32. Glaucoma *Y N*

10. A stroke (taking blood thinners) *Y N* 33. Contact Lenses *Y N*

11. Anemia or other blood disorder *Y N* 34. Head or Neck Injuries *Y N*

12. Prolonged bleeding due to a slight cut (INR>3.5) *Y N* 35. Epilepsy, convulsions (seizures) *Y N*

13. Pneumonia, emphysema, shortness of breath *Y N* 36. Neurological disorders (ADHD, prion

14. Tuberculosis, measles, chicken pox *Y N* disease) *Y N*

15. Asthma *Y N* 37. Viral infections and cold sores *Y N*

16. Breathing/sleep problems (i.e. sleep apnea, snoring) *Y N* 38. Hives, skin rash, hay fever *Y N*

17. Kidney Disease *Y N* 39. Any lumps or swelling in the mouth *Y N*

18. Liver Disease *Y N* 40. STI/STD/HPV *Y N*

19. Jaundice *Y N* 41. Hepatitis (type A B C ) Y N

20. Thyroid, parathyroid disease, or calcium deficiency *Y N* 42. HIV/AIDS *Y N*

21. Hormone deficiency *Y N* 43. Diabetes (HbA1c= ) *Y N*

22. High cholesterol or taking statin drugs *Y N* 44. Alcohol, recreational drugs *Y N*

23. Emotional difficulties *Y N* 45. Antidepressant medication *Y N*

24. Chemotherapy, immunosuppressive meds *Y N* 46. Psychiatric treatment *Y N*

25. Tumour, abnormal growth *Y N* 47. Emotional difficulties *Y N*

26. Radiation therapy *Y N*

***ALLERGIES***

*☐* aspirin, ibuprofen, acetaminophen, codeine *☐* local anaesthetic

*☐* penicillin *☐* metal (nickel, gold, silver, )

*☐* erythromycin *☐* fluoride

*☐* tetracycline *☐* latex

*☐* sulfa *☐* nuts

*☐* other *☐* fruit

**ARE YOU**

**1**. Presently being treated for any other illness *Y N* 7. Experiencing frequent headaches *Y N*

2. Aware of a change in your health in the last 24 8. A smoker/smokeless tobacco user

 hours (i.e. fever, chills, diarrhea) *Y N* now/previously *Y N*

3. Taking medication for weight management *Y N* 9. Considered a touchy/sensitive person *Y N*

4. Taking dietary supplements *Y N* 10. Often unhappy or depressed *Y N*

5. Often exhausted or fatigued *Y N* 11. Taking birth control pills *Y N*

6. Currently pregnant *Y N* 12. Diagnosed with a prostate disorder *Y N*

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may affect your dental treatment (i.e. Botox, collagen injections)

**List all medications, supplements, and vitamins taken within the last 2 years, and please advise us of any changes in the future.**

Drug Purpose Drug Purpose

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Patient name printed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO**

**PERSONAL HISTORY**

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) Y N

2. Have you had an unfavourable dental experience? *Y N*

3. Have you ever had complications from past dental treatment? *Y N*

4. Have you ever had trouble getting numb or had any reactions to local anaesthetic? *Y N*

5. Did you ever have braces, orthodontic treatment, or had your bite adjusted, and at what age? *Y N*

6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? *Y N*

**GUM AND BONE**

7. Do your gums bleed or are they painful when brushing or flossing? *Y N*

8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? *Y N*

9. Have you ever noticed an unpleasant taste or odour in your mouth? *Y N*

10. Is there anyone with a history of periodontal disease in your family? *Y N*

11. Have you ever experienced gum recession? *Y N*

12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? *Y N*

13. Have you ever experienced a burning or painful sensation in your mouth not related to your teeth? *Y N*

**TOOTH STRUCTURE**

14. Have you had any cavities within the past 3 years? *Y N*

15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? *Y N*

16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? *Y N*

17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing, any part of your mouth? *Y N*

18. Do you have any grooves or notches on your teeth near the gum line? *Y N*

19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? *Y N*

20. Do you frequently get food caught between your teeth? *Y N*

**BITE AND JAW JOINT**

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) *Y N*

22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? *Y N*

23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? *Y N*

24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? *Y N*

25. Are your teeth becoming more crooked, crowded, or overlapped? *Y N*

26. Are your teeth developing spaces or becoming more loose? *Y N*

27. Do you have trouble finding your bite, need to squeeze, tap your teeth together, or shift your jaw so your teeth fit? *Y N*

28. Do you place your tongue between your teeth or close your teeth against your tongue? *Y N*

29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? *Y N*

30. Do you clench or grind your teeth together in the daytime or make them sore? *Y N*

31. Do you have problems with sleep (restlessness or teeth grinding), wake up with a headache/an awareness of your teeth? *Y N*

32. Do you wear or have you ever worn a bite appliance? *Y N*

**SMILE CHARACTERISTICS**

33. Is there anything about the appearance of your teeth that you would like to change (shape, colour, size)? *Y N*

34. Have you ever whitened (bleached) your teeth? *Y N*

35. Have you felt uncomfortable or self conscious about the appearance of your teeth? *Y N*

36. Have you been disappointed with the appearance of previous dental work? *Y N*