NEW PATIENT INFORMATION

Patient Last Name:	Mr. Mrs. Dr. Ms.	Given Names:	Birth Date: (MM/DD/ YYYY)
Street Address:	Unit #:	City:	Postal Code:
Home Phone:	Cell Phone:	Work Phone:	Email Address:	Preferred Contact Method:
In case of emergency notify:	Relationship:	Phone Number:
Health Card Number:	Whom may we thank for referring you to our office?
Family Physician:	Phone Number:
Medical Specialist:	Phone Number:
If patient is a minor, person responsible for account:	Relationship to patient:
Address:	Phone Number:

MEDICAL HISTORY	YES	NO	EXPLAIN (If necessary)
Have there been any changes in your general health in the last year? If yes, please explain.			
Is your physician currently treating you for any reasons other than regular check-ups? If yes, please explain.			
Have you been hospitalized within the last year? If yes, please specify.			
Have you had any type of surgery? If yes, please explain.			
Do you bruise easily or bleed excessively when cut?			
Have you ever taken cortisone / steroid medication?			
Are you currently taking any pills, drugs or other medications including natural supplements? If yes, please list.			
Do you smoke or chew tobacco products? If yes, how much?			
Have you ever had an allergic reaction to any medications or injections including dental anaesthetics? If yes, please specify.			

ALLERGIES — **Please check off any medication you are allergic or you have reacted adversely to:**

☐	Aspirin	☐	Advil (Ibuprophen)	☐	Tylenol	☐	Tylenol #2, #3, #4	☐	Naproxen
☐	Torodol	☐	Codiene	☐	Demerol	☐	Percocet	☐	Valium
☐	Penicillin	☐	Ampicillin	☐	Amoxicillin	☐	Erythromycin	☐	Clindamycin
☐	Rovamycin	☐	Cephalexin	☐	Tetracycline	☐	Sulpha Drugs	☐	Local Anaesthetic
☐	Chlorhexidene-Peridex	☐	Metal	☐	Latex	☐	Bandages	☐	

FOOD ALLERGIES: Please list:	
Please list any other medications or substances which you are allergic to:	

MEDICAL CONDITIONS — **Please check off all of the following conditions you presently have, or have had in the past.**

☐	A.I.D.S (HIV Positive)	☐	Anemia / Blood disorders	☐	Angina / Chest pain
☐	Arthritis	☐	Artificial heart valve / Pacemaker	☐	Artificial joints / Hip replacement
☐	Asthma	☐	Cancer / Tumors	☐	Chemotherapy / Radiation
☐	Diabetes	☐	Epilepsy or seizures	☐	Fainting or dizzy spells
☐	Glaucoma / Macular degeneration	☐	Head / Neck injuries	☐	Heart attack / Cardiac arrest
☐	Heart disease / Surgery	☐	Heart murmur	☐	High blood pressure / Hypertension
☐	High cholesterol	☐	Low blood pressure	☐	Kidney disease

	Liver disease / Hepatitis A, B or C		Lung disease / Emphysema		Malignant hyperthermia
	Mental / Nervous disorder		Mitral valve prolapse		Osteoporosis
	Rheumatic / Scarlet fever		Shortness of breath		Sinus trouble
	Stomach / Intestinal problems / Ulcers		Acid reflux		Stroke
	Swelling of the feet / ankles / hands		Thyroid disease		Tuberculosis
	Drug / Alcohol addiction If yes, have you received treatment? Where?				

	Behaviour disorder		Autism		ODD		ADHD		Other

WOMEN ONLY	**YES**	**NO**	
Are you pregnant or suspect you may be? If yes, what is the expected delivery date?			
Are you taking birth control pills?			
Are you taking fertility pills?			
OTHER			
Do you currently have or have had in the past, any disease, condition or problem not listed above? If yes, please specify.			
Do you wish to speak privately about any problems or medical conditions?			

DENTAL HISTORY

Date of your last dental visit:	
Date of your last cleaning:	
Date of your last x-rays:	

CURRENT CONDITIONS	**YES**	**NO**					
Are you suffering from pain right now?							
Are any of your teeth becoming loose?							
Does food get caught between your teeth?							
Are any of your teeth sensitive to:	Hot		Cold	Bitter	Sweet	Biting	Pressure
Is there any swelling or pain of your gums?							
Do you notice any bleeding of your gums when brushing or eating?							
Is there any history of gum disease in your family?							
Have you ever had local anaesthetic (freezing)?			Any complications?				
Have you ever had any teeth extracted?			Any complications?				
Do you have any burning sensation of the lips or tongue?							
Does your mouth tend to get dry?							
Are you aware of bad breath or a bad taste in your mouth?							
Are you aware of any sores or growths in your mouth?							
Have you worn a night guard or any other appliance?							
Are you nervous about having dental treatment done?							
Have you ever had an upsetting experience in a dental office?			Please describe:				

TREATMENTS – Please check all that apply	**YES**	**NO**	
Orthodontic Treatment (to straighten or align teeth) If so, specify with whom and when?			
Oral Surgery (surgery in or about the mouth/jaw joint or implant surgery) If so, specify with whom and when?			
Periodontal Treatment (treatment of the gums) If so, specify with whom and when?			
Are you being followed up by a dental specialist? If so, by whom and why?			
JAW PROBLEMS – Do you have any of the following?	**YES**	**NO**	
Popping/clicking of your jaw joints when opening and closing?			
Pain in your jaw joints, around your ear, or side of your face?			
Difficulty in opening or closing your mouth?			
Pain when clenching your teeth?			
Pain or difficulty when chewing?			

HABITS – Do you:	YES	NO
Clench or grind your teeth while awake or asleep?		
Bite your cheeks or lips?		
Breathe through your mouth while awake or asleep?		
ORAL HYGIENE		
How often do you brush your teeth?		
How often do you floss your teeth?		
Do you use:		

	Rubber tip		Soft-pic		Tongue scraper		Proxy brush		Sulca brush
	Floss threader		Floss handle		Stimu-dent		Fluoride rinse		Mouthwash
	Water Pik								

At this office we would like to provide you with quality dental treatment and total patient care. Your treatment recommendations will be based on a thorough examination and diagnosis. A written estimate can be sent to your insurance company to determine the extent of your coverage for specific procedures. Your appointment time will be reserved especially for you. If you are unable to keep an appointment, please notify us 24 hours in advance.

PRIVACY STATEMENT

While in compliance with the Personal Information Protection and Electronic Documents Act (**PIPEDA**) our office is committed to keeping your personal information private. Westmeadow Dental understands the importance of collecting, using and disclosing your personal health and dental information in a safe and responsible manner. All employees are trained to handle your sensitive information and are accommodating to the guidelines of **PIPEDA**. Do not hesitate to address any questions or concerns about our policies with a member of our team.

GENERAL RELEASE STATEMENT

I certify that I have read, understood and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical questions. I authorize the dentist to perform necessary diagnostic procedures and treatment as required to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided if my insurance coverage may not be all inclusive.

- □ Patient
- □ Parent
- □ Guardian

Date:_____ Signature:_____