



## NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

**PATIENT NAME (SURNAME, GIVEN):** \_\_\_\_\_

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

BIRTHDATE (DD/MM/YY): \_\_\_\_\_ SEX/GENDER: \_\_\_\_\_ HEIGHT/WEIGHT: \_\_\_\_\_

SCHOOL/OCCUPATION: \_\_\_\_\_

HOME ADDRESS (Nº, STREET, CITY, PROVINCE): \_\_\_\_\_

POSTAL CODE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

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

May we leave a voicemail regarding your appointment at these numbers? Yes ☐ No ☐

Are you likely to be available on short notice for future appointments or changes? Yes ☐ No ☐

We would like to send you email and text communications which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us. ☐

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_

RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

**FAMILY PHYSICIAN:** \_\_\_\_\_ PHONE: \_\_\_\_\_

**NAME OF MEDICAL SPECIALIST:** \_\_\_\_\_ AREA OF SPECIALTY: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_

**NAME OF MEDICAL SPECIALIST:** \_\_\_\_\_ AREA OF SPECIALTY: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_

### PARENT/GUARDIAN/CAREGIVER 1 INFORMATION

NAME (SURNAME, GIVEN): \_\_\_\_\_

RELATION: \_\_\_\_\_

ADDRESS (Nº, STREET, CITY, PROVINCE): \_\_\_\_\_ PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

### PARENT/GUARDIAN/CAREGIVER 2 INFORMATION (IF DIFFERENT THAN ABOVE)

NAME (SURNAME, GIVEN): \_\_\_\_\_

RELATION: \_\_\_\_\_

ADDRESS (Nº, STREET, CITY, PROVINCE): \_\_\_\_\_ PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_



## NEW PATIENT FORM

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

### PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE

(E.G. SCHEDULING APPOINTMENTS)

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

### HOW DID YOU HEAR ABOUT US?

- |                                                     |                                                |                                                            |
|-----------------------------------------------------|------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Friend                     | <input type="checkbox"/> Family member         | <input type="checkbox"/> Colleague                         |
| <input type="checkbox"/> Staff member at our office | <input type="checkbox"/> Patient at our office | <input type="checkbox"/> Referral from health professional |
| <input type="checkbox"/> Website/Internet           | <input type="checkbox"/> Advertisement         | <input type="checkbox"/> Saw sign/Office in person         |
| <input type="checkbox"/> Other: _____               |                                                |                                                            |

**Office Policy:** Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

\_\_\_\_\_  
Signature      PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐      Date

### INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING)

SUBSCRIBER: \_\_\_\_\_  
RELATION: \_\_\_\_\_  
INSURANCE CO: \_\_\_\_\_  
POLICY PLAN #: \_\_\_\_\_  
DIVISION/SECT.#: \_\_\_\_\_  
SUBSCRIBER ID: \_\_\_\_\_

SUBSCRIBER: (SECONDARY) \_\_\_\_\_  
RELATION: \_\_\_\_\_  
INSURANCE CO: \_\_\_\_\_  
POLICY PLAN #: \_\_\_\_\_  
DIVISION/SECT.#: \_\_\_\_\_  
SUBSCRIBER ID: \_\_\_\_\_



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

PATIENT DENTAL HISTORY

1. Reason for today's visit: \_\_\_\_\_  
\_\_\_\_\_
2. Do you have a dental problem that needs to be addressed as soon as possible? ..... Yes ☐ No ☐
3. Have you been visiting the dentist regularly? ..... Yes ☐ No ☐
4. Last dental visit \_\_\_\_\_ Cleaning \_\_\_\_\_ X-rays \_\_\_\_\_
5. How often do you brush your teeth? \_\_\_\_\_ Floss your teeth? \_\_\_\_\_
6. Do your gums bleed regularly? ..... Yes ☐ No ☐
7. Are your teeth sensitive to ..... Hot ☐ Cold ☐ Biting ☐ Sweets ☐ Sour ☐ N/A ☐
8. Do you feel any pain in your teeth? ..... Yes ☐ No ☐
9. Have you ever had any head, neck, or jaw injuries/surgery? ..... Yes ☐ No ☐
10. Do you have dry mouth or difficulty swallowing? ..... Yes ☐ No ☐
11. Do you snore or have sleep apnea? ..... Yes ☐ No ☐
12. Does your jaw crack, click or pop when opened widely? ..... Yes ☐ No ☐
13. Do you grind or clench your teeth during the day or night? ..... Yes ☐ No ☐
14. Do you bite your lips/cheeks frequently? ..... Yes ☐ No ☐
15. Have you ever experienced any growths, lumps or sore spots in your mouth? ..... Yes ☐ No ☐
16. Have you noticed any loosening/movement of your teeth? ..... Yes ☐ No ☐
17. Have you had periodontal (gum) treatment? ..... Yes ☐ No ☐
18. Have you had orthodontic (braces) treatment? ..... Yes ☐ No ☐
19. Have you ever had treatment by a dental specialist? ..... Yes ☐ No ☐
20. Have you had previous problems with dental treatment? ..... Yes ☐ No ☐
21. Are you satisfied with the appearance of your teeth? ..... Yes ☐ No ☐
22. Are you nervous/anxious/fearful during dental treatment? ..... Yes ☐ No ☐
23. Please list any other information that you feel we should have to provide you with the best possible dental care:  
\_\_\_\_\_  
\_\_\_\_\_

Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐

\_\_\_\_\_ Date

Reviewed By Dentist

\_\_\_\_\_ Date



## NEW PATIENT FORM

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

### MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

1. Do you have any health problems? ..... Yes ☐ No ☐  
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
2. Has there been any change in your general health or weight in the past year? ..... Yes ☐ No ☐  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
3. Are you currently being treated for any medical condition or have been treated in the last year? ..... Yes ☐ No ☐  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. When was the last time you had a medical examination? \_\_\_\_\_  
Were any problems identified? ..... Yes ☐ No ☐  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
5. Have you ever been hospitalized for any illnesses or operations? ..... Yes ☐ No ☐  
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
6. Are you taking any medications, non-prescription drugs, homeopathic or herbal supplements, or hormones of any kind? ..... Yes ☐ No ☐  
If yes, please list and provide reason for taking: \_\_\_\_\_  
\_\_\_\_\_
7. Do you have any allergies or reactions? ..... Yes ☐ No ☐  
If yes, please list using the categories below:  
Medications \_\_\_\_\_  
Latex/rubber derived products \_\_\_\_\_  
Other (e.g. seasonal, foods, dyes) \_\_\_\_\_
8. Have you had an adverse reaction to any dental materials, injections or local anaesthetic? ..... Yes ☐ No ☐  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
9. Do you have or have you ever had a replacement or a 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 ☐  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
10. Have you been advised to take pre-medication (e.g. antibiotics) prior to dental treatment? ..... Yes ☐ No ☐  
If yes, please explain: \_\_\_\_\_
11. Do you have a prosthetic or artificial joint? ..... Yes ☐ No ☐  
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_

MEDICAL HISTORY CONTINUED ON NEXT PAGE



## NEW PATIENT FORM

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

### MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

12. Do you have any conditions or have undergone therapies that could affect your immune system? ..... Yes ☐ No ☐  
(Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)

If yes, please explain: \_\_\_\_\_

13. Have you ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders? ..... Yes ☐ No ☐

If yes, please explain: \_\_\_\_\_

14. Do you have a bleeding problem, bleeding disorder, bruising tendency, or have had a blood transfusion? ..... Yes ☐ No ☐

If yes, please explain: \_\_\_\_\_

15. Do you have any or have you ever had any of the following (check all that apply): ..... Yes ☐ No ☐

- |                                                |                                               |                                                                                 |
|------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> Fainting/Dizzy spells | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Hyper/Hypoglycemia                                     |
| <input type="checkbox"/> Eating disorder       | <input type="checkbox"/> Steroid therapy      | <input type="checkbox"/> Mental or Nervous disorder                             |
| <input type="checkbox"/> Stroke/TIA            | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Circulatory problems                                   |
| <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> Stomach ulcers       | <input type="checkbox"/> Blood transfusion                                      |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Other communicable disease/<br>Transmissible infection |
| <input type="checkbox"/> Heart murmur          | <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> Chest pain/Angina/Heart attack                         |
| <input type="checkbox"/> Asthma or Emphysema   | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Drug/Alcohol/Cannabis use or dependency                |
| <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Seizures/Epilepsy    | <input type="checkbox"/> Shortness of breath                                    |
| <input type="checkbox"/> Lung disease          | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Osteoporosis                                           |
| <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Thyroid disease      |                                                                                 |

16. Are there any conditions or diseases not listed above that you have or have had? ..... Yes ☐ No ☐

If yes, please explain: \_\_\_\_\_

17. Are there any diseases or medical problems that run in your family? ..... Yes ☐ No ☐  
(e.g. diabetes, cancer, or heart disease)

18. Do you smoke, vape, use e-cigarettes or chew tobacco products? ..... Yes ☐ No ☐

19. Are you pregnant? ..... Yes ☐ No ☐

If yes, what is the expected delivery date: \_\_\_\_\_

20. Are you breastfeeding? ..... Yes ☐ No ☐

MEDICAL HISTORY CONTINUED ON NEXT PAGE



## NEW PATIENT FORM

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

### MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

21. Do you identify as a person with a disability? ..... Yes ☐ No ☐  
If yes, please explain: \_\_\_\_\_
22. Have you recently travelled to areas where endemic diseases are present? ..... Yes ☐ No ☐
23. Have you recently experienced any new symptoms such as a cough, fever, chills, vomiting, diarrhea, rash or other illness since recent travel or otherwise? ..... Yes ☐ No ☐
24. Have you had a recent exposure to a communicable infectious disease? ..... Yes ☐ No ☐  
(e.g. measles, chicken pox or tuberculosis)
25. Have you recently received antimicrobial therapy? ..... Yes ☐ No ☐  
If so, for what reason? \_\_\_\_\_
26. Are your immunizations up to date? ..... Yes ☐ No ☐
27. Is there any additional information related to your health that has not been addressed above? ..... Yes ☐ No ☐  
If so, please advise: \_\_\_\_\_

Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐

\_\_\_\_\_

Date

Reviewed By Dentist

\_\_\_\_\_

Date