dental
comfort care dentistry
#221, 736 Eighth Ave. S.W. Calgary, Alberta
(403)269-8440

CONFIDENTIAL PATIENT RECORD

The information requested on this Questionnaire, Dental History and Medical History is essential to providing you with the safest and highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly.

REGISTRATION INFORMATION

Patient's last name: First: Middle: ❑ Adult ❑ Child			❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street Address:		Postal Code:	City:		
Home Phone #: ( )	Cell #: ( )		Work #: ( )		
Occupation:	Employer:		E-mail:		
❑ Would you prefer to be reminded of your future appointments using e-mail address? (Highly recommended)					
What is your preferred appointment time: What days of the week do you prefer appointments on:					
Who can we thank for your referral to our office? Name of person:					
❑ Family	❑ Friend	❑ Close to home/work	❑ Drive By	❑ Internet/Website ❑ Other	
Other family members seen here:					
Emergency Contact:	Relationship to patient:		Phone #: ( )		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company Name:					
Subscriber's Name:			Birth date: / /	Policy#:	ID#:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary Insurance Company Name:					
Subscriber's Name:			Birth date: / /	Policy#:	ID#:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

MEDICAL HISTORY

Name of Physician:	Phone#: ( )

Please ✓ YES or NO to each question, if YES explain. If unsure of a question, please consult with dental professional

1. Are you currently being treated for any medical condition at present or within the past 2 years?	❑ Yes	❑ No
2. Have you been hospitalized in the past two years?	❑ Yes	❑ No
3. When was your last visit to a Physician?		
4. Have you recently, or are you presently, taking any prescription or non-prescription drugs including herbal remedies?	❑ Yes	❑ No
1. 2. 3.		
4. 5. 6.		

5. Have you ever reacted adversely to any medications or injections? (please circle) e.g. Penicillin, or other antibiotics, aspirin, codeine, local anesthetic (freezing),, or any other medicine:	❑ Yes	❑ No
6. Had you ever been advised against taking any specific type of medication?	❑ Yes	❑ No
7. Do you have any of the following? Asthma, Hay fever, food allergies, metal or latex allergies, skin rashes, hives, or any other allergic conditions?	❑ Yes	❑ No
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction?	❑ Yes	❑ No
9. Is there a family history of diabetes, pancreatic cancer or other cancer, heart disease or periodontal disease?	❑ Yes	❑ No
10. Do you bleed excessively from a cut or injury, or bruise easily?	❑ Yes	❑ No
11. Have you tested HIV positive?	❑ Yes	❑ No
12. Do you have frequent severe headaches, earaches, ear/throat infections?	❑ Yes	❑ No
13. Have you ever had any injury or surgery to your face or jaws?	❑ Yes	❑ No
14. Do you have hearing difficulties?	❑ Yes	❑ No
15. Do you smoke or use any other forms of tobacco?	❑ Yes	❑ No
Are you wearing a transdermal nicotine patch?	❑ Yes	❑ No
16. Are you regularly using alcohol and/or drug s?	❑ Yes	❑ No

17. **INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:**

A.I.D.S	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Lupus	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Head/neck injuries	❑ Yes	❑ No	Malignant hypothermia	❑ Yes	❑ No
Angina pectoris	❑ Yes	❑ No	Heart disease or attack	❑ Yes	❑ No	Mental/nervous disorder	❑ Yes	❑ No
Arthritis/rheumatism	❑ Yes	❑ No	Heart murmur	❑ Yes	❑ No	Mitral valve prolapse	❑ Yes	❑ No
Artificial heart valve	❑ Yes	❑ No	Heart pacemaker	❑ Yes	❑ No	Organ transplant/medical implant	❑ Yes	❑ No
Artificial joints (hip/knee)	❑ Yes	❑ No	Heart rhythm disorder	❑ Yes	❑ No	Psychiatric treatment	❑ Yes	❑ No
Blood disorders	❑ Yes	❑ No	Heart surgery	❑ Yes	❑ No	Radiation treatment/chemotherapy	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No	Hepatitis A B C ___	❑ Yes	❑ No	Scarlet fever/rheumatic fever	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Sickle cell disease	❑ Yes	❑ No
Circulation problems	❑ Yes	❑ No	High/low blood pressure	❑ Yes	❑ No	Sinus trouble	❑ Yes	❑ No
Congenital heart lesions	❑ Yes	❑ No	Hodgkin's disease	❑ Yes	❑ No	Stomach/ intestinal problems/ulcers	❑ Yes	❑ No
Cortisone/steroids	❑ Yes	❑ No	Hyper (hypo) Glycaemia	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Crohn's disease	❑ Yes	❑ No	Hypertension	❑ Yes	❑ No	Thyroid disease	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Inflammatory bowel disease	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Venereal disease	❑ Yes	❑ No
Epilepsy or seizures	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No			
Fainting or dizzy spells	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No			
Glandular disorders	❑ Yes	❑ No	Lung disease	❑ Yes	❑ No			

18. Has the **CHILD PATIENT** recently			Measles	❑ Yes	❑ No			
Had any of the following:			Mumps	❑ Yes	❑ No	Strep throat	❑ Yes	❑ No
(Indicate approximate date)			Chickenpox	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No

19. Do you currently have, or have you had in the past, any disease, condition or problem not listed above?	❑ Yes	❑ No
20. Is there anything else about your health we should be made aware of?	❑ Yes	❑ No
21. **Women only:** are you pregnant or suspect you may be? Expected delivery date?	❑ Yes	❑ No
Are you breastfeeding?	❑ Yes	❑ No
Are you taking any birth control pills?	❑ Yes	❑ No
Women over 50: are you aware of your bone mineral density?	❑ Yes	❑ No

DENTAL HISTORY

Please ✓ YES or NO to each question, if YES explain. If unsure of a question, please consult with dental professional

Is there a dental problem you would like treated immediately?	❑ Yes	❑ No
Date of your last dental visit? Last dental cleaning? Last X-rays?		
1. Have you been seeing a dentist regularly?	❑ Yes	❑ No
2. Have you ever had any of the following?		
Periodontal treatment? (treatment of the gums)	❑ Yes	❑ No
Orthodontic treatment? (Appliances or braces)	❑ Yes	❑ No
A Bite plate or any other appliance? (e.g. Month Guard, Night Guard)	❑ Yes	❑ No
Your bite adjusted or teeth ground?	❑ Yes	❑ No
Oral surgery? (Surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	❑ Yes	❑ No
If you answered yes to the last question, who performed the surgery? When?		
Are you being followed up by a dental specialist?	❑ Yes	❑ No
3. Are there any abnormal or sore spots in your mouth?	❑ Yes	❑ No
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?	❑ Yes	❑ No
5. Have you noticed any loose teeth, or teeth that have shifted?	❑ Yes	❑ No
6. Does food catch between your teeth?	❑ Yes	❑ No
7. Are any of your teeth sensitive to heat, cold, sweets or pressure?	❑ Yes	❑ No
8. **Have you been advised to take antibiotics before a dental appointment?**	❑ Yes	❑ No
9. Do you use dental floss, proxabrush, or stimudents? How often?	❑ Yes	❑ No
10. How often do you brush your teeth? Do you feel that you have bad breath?	❑ Yes	❑ No
11. Have you ever experienced any of the following jaw problems:		
Do you suffer from headaches?	❑ Yes	❑ No
Popping/clicking in your jaw joints?	❑ Yes	❑ No
Pain in your jaw joints, around your ear, or the side of your face?	❑ Yes	❑ No
Difficulty in opening or closing?	❑ Yes	❑ No
Pain or difficulty when chewing?	❑ Yes	❑ No
12. Do you have any of the following habits?		
Clenching or grinding your teeth while awake or asleep?	❑ Yes	❑ No
Biting your cheeks or lips?	❑ Yes	❑ No
Placing foreign objects in your mouth (pencils, pipes, pins, fingernails)?	❑ Yes	❑ No
Mouth breathing while awake or asleep?	❑ Yes	❑ No
Has your bed partner or another individual ever indicate that you gasp for air in your sleep?	❑ Yes	❑ No
Have you ever been screened for sleep apnea?	❑ Yes	❑ No
If yes, are you currently or have you in the past ever received treatment for this sleep breathing disorder? Please specify.		
13. Do you have any concerns about having dental treatment?	❑ Yes	❑ No
14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns?	❑ Yes	❑ No

15. Is there anything you would like to change about the appearance of your teeth?	❑ Yes	❑ No
If yes, please explain		
16. Do you feel your dental health influences your overall health?	❑ Yes	❑ No
17. On a scale of 1 to 10, 10 being the highest, how important is it for you to keep your natural teeth?		

Patient Height_____ **Patient Weight_____** **BMI_____**

GENERAL RELEASE (please sign after completing medical questionnaire.)

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and received answers to any questions regarding my medical - dental history. Should there be any change in either my health status or any other information I have provided I will advise this dental office. I authorized the dental provider to perform diagnostic procedures as needed to determine necessary treatment. As a patient, I understand that I have the right to:

Be advised of the benefits, options and risks of any dental procedure, ask questions and receive complete answers regarding my dental health, and to make an informed decision to accept or decline recommended treatment.

X

(signature) patient parent guardian *(parent name of guardian)*

Reviewed by: *Date:*