calgaryperio
Periodontal Health & Dental Implants

Patient Dental and Medical Information

GENERAL INFORMATION

Name:________________ ______________________ Sex_____ DOB________ (Date of Birth)
First Last

Address:__________________________________ City:___________ Postal Code_______

Cell Phone:________________ Business Phone: ________________ **Home:**_____________

Occupation___________________ Employer:___________________

Reason for visit to our dental office:_________________ Referred by___________________

Dental Insurance (primary)Company___________ GroupNo.__________ Cert/ID No._________

Secondary Insurance:Name of policy holder:________________________ DOB_________

Company______________ Group No.________________ Cert/ID No.______

MEDICAL INFORMATION AHC #____________________

Physicians Name and contact information:____

Pharmacy Name and contact information:____

Medications List: (Drug/Dose/Duration)

____

____

____

____

History of use of bisphosphonates (osteoporosis) medication in the last 10 years ☐ Yes ☐ No

Have you been informed not to take any specific drug or medication? ☐ Yes ☐ No
Please list____

Do you have **Allergies** or **adverse reactions** to any of the following:

Dental Anaesthesia	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Penicillin or other Antibiotics	☐ Yes	☐ No	Codeine	☐ Yes	☐ No
Latex	☐ Yes	☐ No	Benzodiazepine (sedative)	☐ Yes	☐ No

Please list any **allergies, syptoms** and what type of **management** (ex. epi pen, antihistamine).

____

Do you have or had any of the following medical concerns?

Asthma	☐yes	☐no	HIV Positive/AIDS	☐yes	☐no
Heart Surgery	☐yes	☐no	Hip/Joint replacement	☐yes	☐no
Artificial Heart Valve	☐yes	☐no	Epilepsy	☐yes	☐no
Heart Attack	☐yes	☐no	Diabetes	☐yes	☐no
Heart Murmur	☐yes	☐no	Hepatitis	☐yes	☐no
Pacemaker	☐yes	☐no	Arthritis	☐yes	☐no
High Blood Pressure	☐yes	☐no	Ulcers	☐yes	☐no
Stroke	☐yes	☐no	Tuberculosis	☐yes	☐no
Scarlet Fever	☐yes	☐no	Emphysema	☐yes	☐no

Anaemia	☐yes	☐no	Glaucoma	☐yes	☐no
Abnormal Blood Count	☐yes	☐no	Hives or skin rash	☐yes	☐no
Hemophilia	☐yes	☐no	Hay fever	☐yes	☐no
Major operations	☐yes	☐no	shortness of breath/chest pain	☐yes	☐no
Blood Transfusions	☐yes	☐no	Dry mouth	☐yes	☐no
Tumour or Growth	☐yes	☐no	Tobacco Use	☐yes	☐no
Cancer/Leukemia	☐yes	☐no	How many/years ______		
Radiation/Chemotherapy	☐yes	☐no	When did you stop______		

Please list any disease, or condition not covered.________________________________

Do you have a history of medical surgery or hospitalizations. ☐Yes ☐ No
Details:________________________________

Have you had abnormal bleeding associated with pervious tooth extractions, surgery or trauma? ☐Yes ☐ No
Please list management________________________________
Have you ever had surgery or radiation treatment for a tumor, growth
or condition of your head mouth or lips?

FOR WOMEN ONLY
Are you pregnant at this time? Yes___ NO___ Due Date:________________
Are you taking female hormones oral contraceptives (may be altered with antibiotics)

DENTAL INFORMATION
Please inform us of any Dental Concerns (ex. Difficulty Chewing food, Sensitivity, Discomfort)
____

Are you aware of any of the following:

Bleeding gums:	☐yes	☐no	Esthetic concerns	☐yes	☐no
Bad taste or breath	☐yes	☐no	Shifting/loose teeth	☐yes	☐no
Receding gums	☐yes	☐no	Clenching/grinding	☐yes	☐no
Sensitive teeth	☐yes	☐no	Gagging	☐yes	☐no
Acid reflux	☐yes	☐no	Jaw click or soreness	☐yes	☐no

Do you wear a night guard? ☐Yes ☐No; if yes, when was it fabricated________________
Do you wear a Denture? ☐Yes ☐No; if yes, please indicate type ________________

Have you ever had previous periodontal treatment? ☐Yes ☐ No
When and what sites were involved? ________________________________

Have you ever had orthodontic treatment ? ________________ ☐Yes ☐ No

Have you ever had instruction on how to care for your teeth? ☐Yes ☐ No
Does this include the following:
Soft brush_____, Floss_____, Proxabrush______, Sulca Brush_____
Please answer the following questions related to your personal dental care.
Frequency of brushing________________Firmness of brush________________
Frequency of flossing________________Other dental aids________________
Regularity of cleanings________________________________

Have you ever had complications associated with any previous dental treatment? ☐Yes ☐ No
Please clarify________________________________

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR MEDICATIONS, I WILL INFORM THE DENTAL STAFF AT MY NEXT APPOINTMENT.

Initial

I AM AWARE THAT ALL FEES ARE DUE AT THE TIME OF EACH APPOINTMENT. IF I HAVE DENTAL INSURANCE I WILL PROVIDE THE NECESSARY DETAILS TO THE ADMINISTRATION STAFF FOR PROCESSING OF MY CLAIM FOR REIMBURSEMENT.

Initial

I AM AWARE THAT I HAVE A COMMITMENT TO MY SCHEDULED APPOINTMENTS AS THIS TIME HAS BEEN RESERVED SPECIFICALLY FOR ME. SHOULD I NEED TO RESCHEDULE AN APPOINTMENT I WILL PROVIDE A MINIMUM OF **5** BUSINESS DAYS NOTICE IN ORDER TO AVOID A CANCELLATION FEE.

Signed: ________________________________ Date: ________________