calgaryperio

Patient Dental and Medical Information

GENERAL INFORMATION

Name:_____ _____ Sex_____ DOB_____
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._____
Alberta Health Care Number_____

MEDICAL INFORMATION

Physicians Name and contact information: _____
Pharmacy Name and contact information: _____
Emergency Contact Name and Number: _____
Medications List: (Drug/Dose/Duration):
_____
_____
History of use of bisphosphonates (osteoporosis) medication in the last 10 years :_____
Have you been informed not to take any specific drug or medication?
Please list_____

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

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

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

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

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

FOR WOMEN ONLY

Are you pregnant currently? ☐Yes ☐No If so, when is the due date: _____

Are you taking female hormonal oral contraceptives (may be altered with antibiotics) ☐Yes ☐No

DENTAL INFORMATION

Please inform us of any dental concerns (ex; difficulty chewing food, sensitivity, discomfort)

Please list any expectations for your dental treatment_____

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
Jaw click or soreness	☐Yes ☐No	Acid reflex	☐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

If so, When, and what sites were involved? _____

Have you ever had orthodontic treatment? ☐Yes ☐No

If so, when and what sites were involved?_____

Have you ever had instruction on how to care for your teeth? ☐Yes ☐No

Have you been instructed to use any of the following:

Soft brush ☐Yes ☐No Floss ☐Yes ☐No Proxabrush ☐Yes ☐No Sulca brush ☐Yes ☐No

Please answer the following questions related to your personal dental care:

Frequency of brushing_____ electric or manual tooth brush_____

Frequency of flossing_____ other dental aids _____

Regularity of cleanings/Date of last cleaning_____

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

Please clarify_____

Please initial in the boxes

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

☐ 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 MY CLAIM FOR REIMBURSEMENT.

☐ 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 RESCHDULE AN APPOINTMENT I WILL PROVIDE A MINIMUM OF ONE WEEK NOTICE, IN ORDER TO AVOID A CANCELLATION FEE

Signed _____ Date _____