

# P Welcome

Patient Information

Mr  Mrs  Ms  Miss  Dr First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (DD/MM/YY) Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt/Unit#: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Work Number: \_\_\_\_\_ ext. \_\_\_\_\_  
Cell Number: \_\_\_\_\_ Employer: \_\_\_\_\_  
In case of an emergency – Please notify \_\_\_\_\_ Phone Number: \_\_\_\_\_  
May we send you emails/texts about important office notifications, including appointment reminders?  Yes  No  
You have the option to withdraw your consent at any time.  
Health Card: \_\_\_\_\_ Pharmacy: \_\_\_\_\_  
Medical Alert: \_\_\_\_\_ BP: \_\_\_\_\_ INR#: \_\_\_\_\_

Referral Information

## How did you hear about us?

AMS Student Network  Social Media/Email  
 Building Sign  Television  
 Flyer  Community Event: \_\_\_\_\_  
 Internet  Patient..... Name: \_\_\_\_\_  
 Mobile Sign  Radio..... Station(s): \_\_\_\_\_  
 Magazine  Other..... Please specify: \_\_\_\_\_  
 Newspaper

Insurance Information

## Primary Insurance Company Information

Name of Insurance Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (DD/MM/YY)  
Policy Holder Contact Phone Number: \_\_\_\_\_ (if different from above)  
Group Policy/Plan Number: \_\_\_\_\_ I.D./Certificate Number: \_\_\_\_\_  
Marital Status:  Single  Married/Common Law  Other  
Insurance Company Name: \_\_\_\_\_

## Secondary Insurance Company Information

Name of Insurance Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (DD/MM/YY)  
Policy Holder Contact Phone Number: \_\_\_\_\_ (if different from above)  
Group Policy/Plan Number: \_\_\_\_\_ I.D./Certificate Number: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_ Signature: \_\_\_\_\_

*Dawson Dental Centres reserves the right to store outdated/inactive files offsite within the regulations of PHIPA guidelines. Further information would be available to you upon request. Please be aware there may be a nominal fee involved with retrieval of these documents. This would be at the discretion of the practice manager or prescribing doctor. I, the undersigned, agree to the above statements.*

**Patient Name (Please Print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Patient  Parent  Guardian  Patient  Parent  Guardian

# P Medical History

Please check any of the following that apply to you:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Heart condition                  | <input type="checkbox"/> HIV positive/AIDS           | <input type="checkbox"/> Cancer - type: _____           | <input type="checkbox"/> Vision Impairment             |
| <input type="checkbox"/> Angina                           | <input type="checkbox"/> Anemia                      | Date: _____   | <input type="checkbox"/> Hearing impairment            |
| <input type="checkbox"/> Heart surgery/procedures         | <input type="checkbox"/> Blood disorders             | Radiation: _____  | <input type="checkbox"/> TMJ (jaw joint) concerns      |
| <input type="checkbox"/> Heart attack                     | <input type="checkbox"/> Hepatitis A/B/C             | Chemotherapy: _____                                     | <input type="checkbox"/> Physical impairment           |
| <input type="checkbox"/> Stroke/T.I.A                     | <input type="checkbox"/> Hemophilia                  | Surgery: _____  | <input type="checkbox"/> Arthritis                     |
| <input type="checkbox"/> Heart murmur                     | <input type="checkbox"/> Excessive bleeding/bruising | <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Osteoporosis                  |
| <input type="checkbox"/> Mitral valve prolapse            | <input type="checkbox"/> Immunodeficiencies          | <input type="checkbox"/> Respiratory conditions         | <input type="checkbox"/> Long-term Actonel/Fosomax use |
| <input type="checkbox"/> Congenital heart disease         | <input type="checkbox"/> Eating disorder             | <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Epilepsy/seizures             |
| <input type="checkbox"/> Infective Endocarditis           | <input type="checkbox"/> Lupus                       | <input type="checkbox"/> Snoring/sleep apnea            | <input type="checkbox"/> Cognitive impairment          |
| <input type="checkbox"/> Pacemaker                        | <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Dizziness/fainting             | <input type="checkbox"/> Depression                    |
| <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Kidney disease              | <input type="checkbox"/> HPV                            | <input type="checkbox"/> Anxiety                       |
| <input type="checkbox"/> Low blood pressure               | <input type="checkbox"/> Liver disease               | <input type="checkbox"/> Herpes/cold sores              | <input type="checkbox"/> Mental health issues          |
| <input type="checkbox"/> General Anesthetic complications | <input type="checkbox"/> Joint replacement           | <input type="checkbox"/> Ulcers/acid reflux             | <input type="checkbox"/> Drug/alcohol dependency       |
| <input type="checkbox"/> Diabetes: Type I or II           | joint _____  | <input type="checkbox"/> Intestinal/stomach problems    | <input type="checkbox"/> Tobacco Use                   |
| <input type="checkbox"/> Hypoglycemia                     | date _____   | <input type="checkbox"/> Above average weight gain/loss | <input type="checkbox"/> Other _____                   |

Do you have any allergies or sensitivities to Medications: \_\_\_\_\_  
 Food: \_\_\_\_\_  
 Environment: \_\_\_\_\_

Has your physician ever told you to take antibiotics prior to dental procedures?  Yes  No

Have you ever experienced complications following a medical or dental procedure?  Yes  No

Are you pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_ weeks

Is there anything else you think we should know regarding your medical history?  Yes  No

If yes, please describe \_\_\_\_\_

Are you taking any medications?  Yes  No

If yes, please specify \_\_\_\_\_

Family Physician's Name: \_\_\_\_\_ Physician's Phone Number: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

## Information for our Patients

At Dawson Dental Centres, all professional dental services are performed by licensed members of the Royal College of Dental Surgeons ("Dental Professionals"), and all institutional health care services are performed independently by Dawson Dental Centres Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Dawson Dental Centres and Dawson Dental Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Dawson Dental Centres.

## Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Dawson Dental Centres; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Dawson Dental Centres to provide the services you are requesting.

## Acknowledgment regarding Information Provided

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 receive answers 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. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Dawson Dental Centres and Dawson Dental Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Dawson Dental Centres and Dawson Dental Health Services in accordance with their current practices, which may involve transfer and retention offsite. I, the undersigned, acknowledge that the Dawson Dental Centres and Dawson Dental Health Services are relying upon the information which I have provided being accurate and complete.

Patient (Please Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient  Parent  Guardian  Patient  Parent  Guardian

Dentist (Please Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# P Dental History

Name: \_\_\_\_\_

What is the most important thing to you about your visit today? \_\_\_\_\_

Date of most recent dental visit other than a cleaning \_\_\_\_\_

I routinely see my dentist every:                      3mos                      6mos                      12mos                      Not routinely

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_

On a scale of 1 to 10, with 10 being the highest rating...

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
How fearful of dental treatment are you?	1	2	3	4	5	6	7	8	9	10

## Personal History

	Yes	No
Have you ever had an unfavourable dental experience? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had complications from past dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any teeth removed? _____	<input type="checkbox"/>	<input type="checkbox"/>

## Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever whitened your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you self conscious about your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been disappointed with the appearance of previous dental work? _____	<input type="checkbox"/>	<input type="checkbox"/>

## Bite and Jaw Joint

Do you have any problems chewing gum? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any problems chewing bagels or other hard foods? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth crowding or developing spaces? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have to clench to make your teeth fit together? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up feeling like you have been clenching or grinding your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have tension headaches or sore teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear or have you ever worn a bite appliance? _____	<input type="checkbox"/>	<input type="checkbox"/>

## Tooth Structure

Have you had any cavities within the past 3 years? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are any teeth sensitive to hot, cold, biting or sweets? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>

## Gum and Bone

Have you ever been diagnosed or treated for periodontal (gum) disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced gum recession? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is there anyone with a history of periodontal disease in your family? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing, flossing, eating? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth becoming loose? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed an unpleasant taste or odour in your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced a burning sensation in your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>