EARLSBRIDGE DENTAL

Unit 9, 10 Earlsbridge Blvd.
Brampton, ON, L7A 3P1

(905) 846-6661

info@earlsbridgedental.com
www.earlsbridgedental.com

Medical/Dental History

Patient Information

Title | Patient Name | Birth Date | Age

Gender
○ Male ○ Female ○ Other

Marital Status
○ Married ○ Single ○ Divorced ○ Widowed ○ Separated ○ Living with a person

Address | City | Province | Postal Code

Home Phone | Work Phone | Mobile Phone | Email

How did you hear about us?

Preferred method of contact?
○ Phone ○ Text/SMS ○ Email

Adult Patient ○ Yes ○ No

Occupation

Employer

Child Patient ○ Yes ○ No

Parent 1 Name | Parent 1 Phone

Parent 2 Name | Parent 2 Phone

Person Responsible for Account

Name of Family Doctor | Doctor's Phone #

In Case of Emergency, we should notify:

Emergency Contact Name | Relationship | Phone #

Medical Information

1. Are you being treated for any medical condition at the present or have you been treated within the past year?
○ Yes ○ No If yes, please explain

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year?
○ Yes ○ No If yes, please explain

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
○ Yes ○ No If yes, please list medications and dosage

5. Do you have any allergies?

○ Yes ○ No

If yes, please list (eg: medication, latex/rubber products, others)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections?

○ Yes ○ No

If yes, please explain

7. Do you have or have you ever had asthma?

○ Yes ○ No

8. Do you have or have you ever had any heart or blood pressure problems?

○ Yes ○ No

9. Do you have or have you ever had an artificial 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. Do you have a prosthetic or artificial joint?

○ Yes ○ No

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?

○ Yes ○ No

12. Have you ever had hepatitis, jaundice or liver disease?

○ Yes ○ No

13. Do you have a bleeding problem or bleeding disorder?

○ Yes ○ No

14. Have you ever been hospitalized for any illness or operations?

○ Yes ○ No

If yes, please explain

15. Do you have or have you ever had any of the following?

☐ chest pain, angina	☐ shortness of breath	☐ heart attack
☐ rheumatic fever	☐ mitral valve prolapse	☐ heart murmur
☐ pacemaker	☐ lung disease	☐ tuberculosis
☐ stroke	☐ steroid therapy	☐ diabetes
☐ stomach ulcers	☐ arthritis	☐ seizures (epilepsy)
☐ kidney disease	☐ thyroid disease	☐ cancer
☐ osteoporosis medications	☐ drug/alcohol dependency	

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 (e.g. diabetes, cancer, heart disease)?

○ Yes ○ No

If yes, please explain

18. Do you smoke or chew tobacco products?

○ Yes ○ No

19. Are you nervous during dental treatment?

○ Yes ○ No

20. WOMEN ONLY - Are you:

Pregnant?

○ Yes ○ No

If yes, how many months?

Nursing?

○ Yes ○ No

Taking Birth Control Pills?

○ Yes ○ No

Dental Information

1. When was your last dental visit & reason?

2. How often do you visit the dentist?

3. How often do you brush your teeth?

4. How often do you floss your teeth?

5. Do any of the following cause tooth discomfort?

☐ Cold ☐ Hot ☐ Sweets ☐ Chewing

6. Are you having any problems that require immediate attention?

○ Yes ○ No

If yes, please explain

7. Do your gums bleed when you brush your teeth?

○ Yes ○ No

8. Have you noticed any loose teeth?

○ Yes ○ No

9. Do you clench or grind your teeth?

○ Yes ○ No

If yes, do you wear a Nightguard?

10. Have you been diagnosed with sleep apnea?

○ Yes ○ No

If yes, do you wear a CPAP mask?

11. Have you ever had orthodontic treatment (Braces or Invisalign?)

○ Yes ○ No

12. Are you interested in straightening your teeth?

○ Yes ○ No

13. Are you interested in whitening?

○ Yes ○ No

14. Are you interested in crowns or implants?

○ Yes ○ No

15. Have you ever had any complications or issues with previous dental treatment?

16. Please list anything else not mentioned above regarding your past dental history.

Primary Insurance Information

Secondary Insurance Information (If Applicable)

Insurance Coverage

Yes No

Policy holder's name | Policy holder's date of birth

Your insurance company/carrier | Group or policy number

I.D./Certificate No | Employer

Insurance Coverage

Yes No

Policy holder's name | Policy holder's date of birth

Your insurance company/carrier | Group or policy number

I.D./Certificate No | Employer

Cancellations & Missed Appointments

Your appointment time has been reserved exclusively for you to see the dentist or hygienist. We ask that you give us at least 48 hours advance notice when cancelling your scheduled appointment so that we may offer the time to another patient. Appointments that are cancelled with less than 48 hours notice and missed appointments are subject to $50.00 fee. This fee will be due in full prior to your next scheduled appointment.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history, and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. Should there be any change in either my health status or any other information I have provided, I will advise Alpha-Dental office. I authorize the dentist to perform all diagnostic procedures including and not limited to x-rays and photographs, as may be required to determine necessary treatment, and to perform necessary or advisable treatment. I understand that information provided from or to my medical doctor or another healthcare provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that my dental insurance may not cover entirely the total fee of services provided. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

First & Last Name | Email Address

Signature

X ----------