ST. CLAIR DENTAL ASSOCIATES
midtown centre for dental implants

PATIENT INFORMATION (CONFIDENTIAL) DATE:_____

NAME:_____ADDRESS:_____

POSTAL CODE:_____ CITY:_____HOME PHONE:_____CELL:_____

WORK:_____EXT._____DATE OF BIRTH:_____AGE:____SEX:____MARITAL STATUS:____

EMAIL:_____HEALTH CARD NO.:_____

SPOUSE OR PARENT'S NAME:_____EMPLOYER:_____

EMERGENCY CONTACT NAME:_____PHONE:_____

NAME OF SCHOOL (IF STUDENT):_____GRADE:_____

WHOM MAY WE THANK FOR REFERRING YOU:_____

PLEASE INDICATE YOUR PERMISSION FOR THE FOLLOWING:

	YES	NO
-ALLOW EMAILS FROM PRACTICE	____	____
-APPOINTMENT REMINDERS BY EMAIL	____	____
-APPOINTMENT REMINDERS BY SMS	____	____
-MONTHLY NEWSLETTER	____	____
-ACCOUNT STATEMENTS	____	____

INSURANCE INFORMATION

NAME OF INSURED:_____DATE OF BIRTH:_____

EMPLOYER/GROUP POLICY HOLDER:_____INSURANCE COMPANY:_____

PHONE:_____POLICY #:_____CERTIFICATE#:_____

IF YOU HAVE ADDITIONAL INSURANCE PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED:_____ _____DATE OF BIRTH:_____

EMPLOYER/GROUP POLICY HOLDER:_____INSURANCE COMPANY:_____

PHONE:_____POLICY#:_____CERTIFICATE#:_____

PATIENT DENTAL HISTORY

Please note that prior to any treatment our office requires a complete dental and medical history. Knowing any health problems that you have and/or medications that you may be taking can avoid problems when treatment commences. Thank you for taking the time to answer these questions.

PATIENT'S NAME:_____DATE:_____

REASON FOR THIS VISIT_____

WHEN WAS YOUR LAST DENTAL VISIT? WHAT WAS DONE THEN?_____

HOW FREQUENTLY DID YOU VISIT THE DENTIST BEFORE THEN?_____

PREVIOUS DENTIST (NAME & LOCATION):_____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL X-RAYS TAKEN? IF SO, WHEN?_____

HOW OFTEN DO YOU BRUSH AND FLOSS YOUR TEETH?_____

		YES	NO
1.	DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ……	___	___
2.	ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ……..	___	___
3.	ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ……	___	___
4.	DO YOU FEEL DISCOMFORT/ PAIN WITH ANY OF YOUR TEETH? ……	___	___
5.	DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ……	___	___
6.	HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? ……	___	___
7.	HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS WITH YOUR JAW?		
	-CLICKING OR GRINDING NOISES ……..	___	___
	-PAIN (JOINT, EAR, SIDE OF FACE) ……..	___	___
	-DIFFICULTY IN OPENING OR CLOSING ……..	___	___
	-DIFFICULTY IN CHEWING ……..	___	___
	-DO YOU CLENCH OR GRIND YOUR TEETH ……	___	___
8.	DO YOU HAVE FREQUENT HEADACHES? ……	___	___
9.	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? ……	___	___
10.	HAVE YOU NOTICED ANY TEETH BECOMING LOOSE? ……	___	___
11.	DOES FOOD HAVE A TENDENCY TO BECOME CAUGHT BETWEEN YOUR TEETH? ……	___	___
12.	HAVE YOU EVER HAD PERIODONTAL (GUM) TREATMENT? ……	___	___
13.	HAVE YOU EVER HAD ORTHODONTIC TREATMENT (BRACES)? ……	___	___
14.	HAVE YOU EVER WORN A BITE PLATE, NIGHTGUARD, OR OTHER APPLIANCE? ……	___	___
15.	HAVE YOU EVER HAD DIFFICULTY WITH EXTRACTIONS IN THE PAST? ……	___	___
16.	HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS? ……..	___	___
17.	DO YOU WEAR FULL OR PARTIAL DENTURES? ……	___	___
	-IF YES, DATE OF PLACEMENT_____		
18.	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS? ……..	___	___
19.	DO YOU HAVE DRY MOUTH ISSUES? ……..	___	___

MEDICAL HISTORY

PATIENT'S NAME:_____DATE OF BIRTH:_____

	YES	NO
- ARE YOU IN GOOD HEALTH? ……..	___	___
- HAVE THERE BEEN CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR? ……..	___	___
- DATE OF YOUR LAST PHYSICAL EXAM_____		
- PHYSICIAN'S NAME/PHONE NUMBER_____		
- ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ……..	___	___
- HAVE YOU EVER BEEN HOSPITALIZED FOR AN OPERATION OR SERIOUS ILLNESS? ……	___	___
PLEASE EXPLAIN_____		
- ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICATION? ……	___	___
IF YES, WHAT MEDICINE(S) ARE YOU TAKING?_____		
_____		
_____		
_____		
- HAVE YOU EVER EXPERIENCED ABNORMAL BLEEDING? ……..	___	___
- DO YOU BRUISE EASILY? ……..	___	___
- HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? ……..	___	___
- HAVE YOU HAD A RECENT WEIGHT LOSS? ……	___	___
- DO YOU USE TOBACCO? ……-……	___	___
- DO YOU OR HAVE YOU EVER USED CONTROLLED SUBSTANCES? ……..	___	___
- DO YOU HAVE ANY DISEASE, CONDITION, OR MEDICAL ISSUES NOT LISTED ABOVE THAT YOU THINK WE SHOULD BE AWARE OF? ……	___	___

WOMEN ONLY:	YES	NO
-ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? ……	___	___
-ARE YOU NURSING? ……..	___	___
-ARE YOU TAKING BIRTH CONTROL PILLS? ……..	___	___

ARE YOU ALLERGIC OR HAVE YOU HAD REACTIONS TO:	YES	NO
- LOCAL ANAESTHETICS OR FREEZING ……..	___	___
- PENICILLIN OR OTHER ANTIBIOTICS ……..	___	___
- BARBITUATES, SEDATIVES, OR SLEEPING PILLS ……	___	___
- ASPIRIN (ASA) ……	___	___
- IODINE ……..	___	___
- LATEX/RUBBER ……..	___	___
- OTHER (PLEASE LIST)_____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
- HEART DISEASE	___	___
- SCARLET/RHEUMATIC FEVER	___	___
- HEART DEFECT (HEART MURMUR/MITRAL VALVE PROLAPSE)	___	___
- HEART TROUBLE, HEART ATTACK, OR ANGINA/CHEST PAIN	___	___
- SHORTNESS OF BREATH	___	___
- PACEMAKER	___	___
- HEART SURGERY/STENTS/ANGIOPLASTY	___	___
- STROKE	___	___
- HIGH/LOW BLOOD PRESSURE	___	___
- CHOLESTEROL	___	___
- SWELLING OF FEET, ANKLES, HANDS	___	___
- HEPATITIS/JAUNDICE/LIVER DISEASE	___	___
- LUNG/BREATHING PROBLEMS/COPD	___	___
- TUBERCULOSIS	___	___
- PERSISTENT COUGH	___	___
- ASTHMA OR HAY FEVER	___	___
- HIVES OR SKIN RASH	___	___
- FAINTING OR DIZZY SPELLS	___	___
- DIABETES	___	___
- AIDS OR HIV INFECTION	___	___
- THYROID PROBLEMS	___	___
- ARTHRITIS OR RHEUMATISM	___	___
- JOINT REPLACEMENT OR IMPLANT	___	___
- BACK/SPINAL PROBLEMS	___	___
- OSTEOPOROSIS	___	___
- STOMACH ULCER	___	___
- KIDNEY TROUBLE	___	___
- CANCER	___	___
- TUMOURS/CYSTS	___	___
- SEXUALLY TRANSMITTED DISEASES	___	___
- EPILEPSY OR SEIZURES	___	___
- ANEMIA	___	___
- GLAUCOMA	___	___
- MENTAL HEALTH CARE	___	___
- CHEMICAL DEPENDENCY	___	___

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE ST. CLAIR DENTAL ASSOCIATES TO RELEASE INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION, (IN ACCORDANCE WITH **THE *PERSONAL HEALTH INFORMATION PROTECTION ACT 2004***), RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE**