Beeton FAMILY DENTAL CENTRE

TODAY'S DATE:_____

PATIENT INFORMATION

❑ Mr. ❑ Ms. ❑ Mrs. ❑ Dr.

Name: _____

Address: _____

City/Postal Code: _____

E-mail Address: _____

Phone: _____ Cell: _____

Birth Date: ____/____/____ Age: ____ ❑ Male ❑ Female
Month Day Year

In Case of Emergency Please Contact: _____

Phone: _____

Who can we thank for referring

PERSON RESPONSIBLE FOR ACCOUNT

❑ Self ❑ Spouse ❑ Parent ❑ Guardian ❑ Other

Name: _____

Address: _____

Phone: _____ Cell: _____

Birth Date: ____/____/____ Age: ____ ❑ Male ❑ Female
Month Day Year

EMPLOYMENT INFORMATION

Employer _____

Work Phone: _____ EXT: _____

Occupation: _____

Union Local: _____

INSURANCE INFORMATION

Primary Insurance – Name of insured:_____

Insurance company: _____

Policy#_____ Cert#_____ Div# _____

Relation: ❑ Self ❑ Spouse ❑ Other Birth Date:____/____/____
Month Day Year

Secondary Insurance – Name of insured:_____

Insurance company: _____

Policy#_____ Cert#_____ Div# _____

Relation: ❑ Self ❑ Spouse ❑ Other Birth Date: ____/____/____
Month Day Year

HISTORY

Family Physician: _____ Phone:_____

Previous Dentist: _____ Phone: _____

Last Dental X-Rays: _____

Last Cleaning: _____

Previous problems with Dental Tx:_____

Are you satisfied with the appearance of your teeth?
Y❑ N❑ Explain: _____

PAST HISTORY

Y❑ N❑ Gum Surgery?
Y❑ N❑ Orthodontics (Braces)
Y❑ N❑ Endodontics (Root Canal)
Y❑ N❑ Oral Surgery
- ❑ Wisdom teeth removal
- ❑ Dental Implants
- ❑ Crowns
- ❑ Bridges
- ❑ Dentures

PLEASE CHECK ALL DENTAL CONCERNS THAT APPLY TO YOU:

TEETH

- ❑ Broken/Chipped/Cracked
- ❑ Missing Tooth or Teeth
- ❑ Decay
- ❑ Loose Teeth
- ❑ Mouth Breathing
- ❑ Difficulty Chewing
- ❑ Food Trap Areas
- ❑ Grinding or Clenching
- ❑ Oral Habits: _____
- ❑ Mouth Sores
- ❑ Sensitive to Hot/Cold
- ❑ Sensitive to Sweets
- ❑ Tooth Pain
- ❑ Sinus Problems
- ❑ Burning Tongue/Lips/ Dry Mouth
- ❑ Gum Surgery
- ❑ Shifting teeth

GUMS

- ❑ Bleeding/Sore Gums
- ❑ Bad Breath
- ❑ Sore or Sensitive
- ❑ Swelling or Lumps

Jaw/Facial Pain Problems

- ❑ Facial Pain
- ❑ Frequent Headaches
- ❑ Jaw Clicks
- ❑ Pain in Cheeks or Temples
- ❑ Difficulty Opening

OTHER CONCERNS OR REASONS FOR VISIT:

_____

_____

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HEALTH HISTORY

This information will be kept strictly confidential and will be used by the dentist to assist in providing optimum treatment. If you have any questions or concerns, our staff will be pleased to assist you.

Y	N	
❑	❑	Are you presently in good health?
❑	❑	Do you use any tobacco products or nicotine substitutes? Type/Frequency:_____
❑	❑	Past surgeries or hospitalizations: _____
❑	❑	Are you taking any medications (prescription or herbal?)? Type: _____
❑	❑	Do you have any allergies? _____

GENERAL

Do you presently have or have you ever had any of the following conditions?

Y	N	
❑	❑	Artificial Joints:_____
❑	❑	Auto Immune Disease
❑	❑	Asthma
❑	❑	Blood Pressure ❑ High ❑ Low
❑	❑	Bleeding Disorder
❑	❑	Cancer: _____
❑	❑	Diabetes: ❑ Type I ❑ Type II
❑	❑	Epilepsy
❑	❑	Fainting
❑	❑	HIV/AIDS
❑	❑	Hepatitis ❑ A ❑ B ❑ C
❑	❑	Heart Murmur
❑	❑	**Other** _____

Y	N	
❑	❑	Heart Disorders/Disease
❑	❑	Mitral Valve Prolapse
❑	❑	Artificial Heart Valves
❑	❑	Pacemaker
❑	❑	Osteoporosis
❑	❑	Rheumatic Fever
❑	❑	Scarlet Fever
❑	❑	Thyroid Disorders
❑	❑	Are you pregnant?
❑	❑	Injury to: ❑ Face ❑ Mouth ❑ Neck ❑ Teeth
❑	❑	Chemotherapy/ radiation therapy

YOUR SMILE ANALYSIS

Y	N	
❑	❑	Do you like the appearance of your teeth?
❑	❑	Are your teeth all in alignment(straight)
❑	❑	Do you have spaces?
❑	❑	Do you like the colour of your teeth?
❑	❑	Do you wish your teeth were whiter?
❑	❑	Are your teeth protruding?

Y	N	
❑	❑	Are there old crowns, bridges,or fillings you don't like looking at?
❑	❑	Are your teeth chipped OR wearing on the biting surfaces?
❑	❑	Are your teeth hidden?
❑	❑	What would you like your smile to look like?

PLEASE NOTE: WE REQUIRE 2 BUSINESS DAYS NOTICE UPON CANCELLATION OF APPOINTMENTS. A FEE OF $50 FOR HYGIENE OR $ 75 FOR DENTIST FOR NO SHOW / MISSED APPOINTMENTS WILL BE CHARGED TO YOUR ACCOUNT.

Patient Release: I certify that I have provided an accurate and complete medical and dental history for myself (or my dependant) and have not omitted any information. I have had the opportunity to ask questions and have received answers regarding any concerns I have regarding my dental treatment. I authorize the dentist to consult with my physician (or specialist) regarding any compromising medical condition in my (or my dependants) medical/dental history. I have also read and understand the Privacy Act given to me to review.

Date:_____ Signature:_____ ❑ Patient ❑ Parent ❑ Guardian

Reviewed by:_____