

NEW PATIENT INFORMATION FORM

First Name: _____ Last Name: _____

Date of Birth: _____ Marital Status: _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

How do you prefer to be contacted? Cell Home Phone Email Work Phone

Who do we call in case of emergency? Name: _____ Phone: _____

Who can we thank for referring you (how did you find out about our practice)?:

Patient: _____ (Relationship) _____ Website

Online / Google Search News Paper Ad Walk by External Signage

Social Media

Personal History

It is important to us that we meet your needs and address your primary concerns therefore we ask you to share the following information leading into your appointment today:

What is your primary concern today: _____

When did this become a concern: _____

How would you describe your last dental experience: _____

What prevented you from returning to your former Dentist?: _____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

Treating everyone like family

345 Jubilee Street
Duncan, BC
V9L 1W9

250-746-0003
admin@cowichanvalleydental.ca
www.cowichanvalleydental.ca

DENTAL HISTORY

Do you have or have you ever had Braces, Orthodontics, Treatment or Upper Bite Adjustment?: Yes No

DENTAL HISTORY

Please answer Yes or No to the following:

YES NO

Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? _____

Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____

Is there anyone with a history of periodontal disease in your family? _____

Have you ever experienced gum recession? _____

Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____

Tooth Structure

Have you had any cavities within the past 3 years? _____

Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____

Do you frequently get food caught between any teeth? _____

Smile Characteristics

33. Is there anything about the appearance of your teeth that you would like to change? _____

34. Have you ever whitened (bleached) your teeth? _____

35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____

36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Your Privacy is Always Assured

Privacy of our patient's personal information is important to us. Personal information is necessary for providing professional oral health care services to you and information necessary to administer your dental treatment.

I authorize communication of this personal information by mail, electronic and verbal means. Personal information includes clinical records, X-rays, study models, photographs of you and your teeth, mouth, smile and face, and general health information obtained from a medical history review, insurance information, phone numbers and email addresses. Clinical information and photographs, x-rays may also be used for long-term follow-up and research purposes, as well as for education or teaching purposes.

Your personal information will only be shared with those who have a need to know and specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include referring dentists, other dental specialists, physician(s), dental laboratories and insurance carriers.

I certify that I have read and understand this document.

Signature/Parent or Guardian: _____ Date: _____

Signature/Parent or Guardian: _____ Date: _____

MEDICAL HISTORY

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

Have you been instructed to take pre-medication prior to dental treatment? _____

Do You Have or Have You Ever Had:	YES	NO		YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	20. thyroid, parathyroid disease, or calcium deficiency_____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to:	<input type="checkbox"/>	<input type="checkbox"/>	21. hormone deficiency_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			22. high cholesterol or taking statin drugs_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			25. digestive disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfalocal			(i.e. celiac disease, gastric reflux)		
<input type="checkbox"/> anesthetic			26. osteoporosis/osteopenia_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			(i.e. taking bisphosphonates)		
<input type="checkbox"/> metals (nickel, gold, silver, _____)			27. arthritis_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			28. autoimmune disease_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			(i.e. rheumatoid arthritis, lupus, scleroderma)		
3. heart problems, or cardiac stent within the last six months_____	<input type="checkbox"/>	<input type="checkbox"/>	29. glaucoma_____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis_____	<input type="checkbox"/>	<input type="checkbox"/>	30. contact lenses_____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO)_	<input type="checkbox"/>	<input type="checkbox"/>	31. head or neck injuries_____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator_____	<input type="checkbox"/>	<input type="checkbox"/>	32. epilepsy, convulsions (seizures)_____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement)_____	<input type="checkbox"/>	<input type="checkbox"/>	33. neurologic disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	(ADD/ADHD, prion disease)		
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners)_____	<input type="checkbox"/>	<input type="checkbox"/>	35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder_____	<input type="checkbox"/>	<input type="checkbox"/>	36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5)	<input type="checkbox"/>	<input type="checkbox"/>	37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis ____	<input type="checkbox"/>	<input type="checkbox"/>	38. hepatitis (type _____)_____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox_____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems_____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
(i.e. sleep apnea, snoring, sinus)			42. biphosphonates_____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	43. chemotherapy, immunosuppressive medication_____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease_____	<input type="checkbox"/>	<input type="checkbox"/>			
19. jaundice_____	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICAL HISTORY

- | | | | | | |
|---|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| | YES | NO | | YES | NO |
| 44. emotional difficulties _____ | <input type="checkbox"/> | <input type="checkbox"/> | 55. currently pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> | 56. prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 47. alcohol / recreational drug use _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections).

Are You:

- | | | | |
|---|--------------------------|--------------------------|-------|
| 48. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 49. aware of a change in your health in the last 24 hours _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| (i.e. fever, chills, new cough, or diarrhea) | | | _____ |
| 50. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 51. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 52. experiencing frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 53. a smoker, smoked previously or use smokeless tobacco _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 54. taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

List all medications, supplements, and or vitamins taken within the last two years.

Please advise us in the future of any change in your medical history or any medications you may be taking.

Drug	Purpose	Drug	Purpose

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

ASA _____ (1-6)