Scottsdale DENTAL CENTRE

Date: _____ How did you hear about our office? _____

**Patient Information:** A parent or guardian will be responsible for decisions on my treatment: □ Yes □ No

Name _____
First Initial Last

Address _____
Street Apt. City Province Postal Code

Date of Birth ___/___/_____ Email _____ Occupation _____
DD/MM/YYY

Work Tel. (____)_____-_____ Mobile Tel. (____)_____-_____ Home Tel. (____)_____-_____

Emergency Contact _____ Relationship _____ Tel. (____)_____-_____

Family Doctor _____ Tel. (____)_____-_____

**Dental History:**

1. What is the reason for your visit? □ Emergency □ Exam □ Other_____
2. How frequently do you see the dentist? □ 3-6 months □ Other_____
3. When was your last dental visit? _____ Last X-rays? _____
4. How often do you brush per day? _____ How often do you floss? _____
   Do you use anti-bacterial rinse? ..... □ Yes □ No
5. Are your teeth sensitive to: □ Cold □ Heat □ Sweets □ Other_____
6. Do your gums bleed when: □ Brushing □ Flossing □ Never
7. Do your gums feel swollen or tender? ..... □ Yes □ No
8. Do you have bad breath or a bad taste in your mouth? ..... □ Yes □ No
9. Do your jaws crack, pop or grate when you open widely? ..... □ Yes □ No
10. Do you grind or clench your teeth? ..... □ Yes □ No
11. Do you have food catch between your teeth? ..... □ Yes □ No
12. Have you ever had local anaesthetic (freezing)? ..... □ Yes □ No
    Any Complications? Specify: _____
13. Have you ever had any problems with previous dental treatments? ..... □ Yes □ No
    Specify: _____
14. Have you ever had any of the following: □ Bridgework □ Crowns or Caps □ Root Canal
    □ Full or Partial Denture □ Orthodontics □ Periodontal (Gums)
15. Are you satisfied with your teeth? □ Yes □ No Specify: _____
16. Are you nervous about dental treatment? ..... □ Yes □ No

**Medical History:** (this information will be confidential)

1. Are you presently under the care of a physician? ..... □ Yes □ No
   If so please explain: _____
2. Have you ever been hospitalized? ..... □ Yes □ No
   Please explain: _____
3. When was your last medical checkup? _____
4. Are you taking any drugs or medication at this time? ..... □ Yes □ No

Drug _____ Reason _____ Drug _____ Reason _____

Drug _____ Reason _____ Drug _____ Reason _____

Drug _____ Reason _____ Drug _____ Reason _____

5. Have you ever had any adverse effect to any of the following: □ **None** □ Latex □ Penicillin □ Aspirin □ Benzodiazepines □ Codeine □ Demerol □ Local Anesthetic □Nitrous Oxide □ Other_____
6. Have you ever been warned against any other medications? ..... □ Yes □ No
   Which? _____
7. Have you ever taken prolonged medical or non-medical drugs? ..... □ Yes □ No
   Which? _____
8. Do you suffer from any allergies? □ Yes □ No Which? _____
9. Do you bruise easily or have prolonged bleeding? ..... □ Yes □ No
10. Do you smoke or vape? How often per day? ..... □ Yes □ No
11. Have you ever fainted, had shortness of breath or chest pains? ..... □ Yes □ No
12. Are there any diseases than run in your family (e.g. diabetes, cancer, heart disease)? ..... □ Yes □ No
13. Do you have or have you ever had any of the following?

| | | |
|---|---|---|
| ☐ A.I.D.S. | ☐ Head/Neck Injuries | ☐ Osteoporosis Medications (e.g. Fosamax, Actonel) |
| ☐ Anemia | ☐ Heart Disease/Heart Attack | |
| ☐ Angina Pectoris/Chest pain | ☐ Heart Murmur | ☐ Pacemaker |
| ☐ Anorexia Nervosa | ☐ Heart Pacemaker/ Surgery | ☐ Psychiatric Disorders |
| ☐ Artificial Hearth Value | ☐ Heart Rhythm Disorder | ☐ Radiation/Chemotherapy |
| ☐ Arthritis/Rheumatism | ☐ Hepatitis A/B/C | ☐ Rheumatic/Scarlet Fever |
| ☐ Artificial Joints (hips, knees) | ☐ Herpes | ☐ Shortness of Breath |
| ☐ Asthma | ☐ High/Low Blood Pressure | ☐ Sickle Cell Disease |
| ☐ Blood Disorders | ☐ H.I.V. Positive | ☐ Sinus Trouble |
| ☐ Bronchitis | ☐ Hodgkin's Disease | ☐ Steroid Therapy |
| ☐ Bulimia | ☐ Hyper (hypo) Glycaemia | ☐ Stomach/Intestinal Problems |
| ☐ Cancer | ☐ Hypertension | ☐ Stroke, TIA |
| ☐ Circulation Problems | ☐ Jaundice | ☐ Thyroid Disease |
| ☐ Congenital Heart Lesions | ☐ Kidney Disease | ☐ Tuberculosis |
| ☐ Cortisone/Steroid | ☐ Liver Disease | ☐ Ulcers |
| ☐ Diabetes | ☐ Leukemia | ☐ Venereal Disease |
| ☐ Drug/Alcohol/Cannabis Use | ☐ Lung Disease | ☐ Osteoporosis |
| ☐ Emphysema | ☐ Malignant Hypothermia | ☐ Other _____ |
| ☐ Epilepsy/seizures | ☐ Mental/Nervous Disorder | ☐ **None of the above** |
| ☐ Glandular Disorders | ☐ Mitral Valve Prolapse | |
| ☐ Glaucoma | ☐ Organ Transplant/Implant | |

*Children:* Have you recently had any of the following (approx. date)?

| | | |
|---|---|---|
| ☐ Chicken Pox _____ | ☐ Measles _____ | ☐ Mumps _____ |
| ☐ Strep Throat _____ | ☐ Tonsillitis _____ | ☐ NONE |

*Women:* Are you pregnant? □ Yes □ No Using birth control? □ Yes □ No Are you breastfeeding? □ Yes □ No Menopause? □ Yes □ No

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**General Release:**

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by my dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature □ Patient □ Parent/Guardian Print Name Date