Orléans Queensway
DENTAL

NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

PATIENT NAME (SURNAME, GIVEN): ____________________

PREFERRED NAME: ____________________

BIRTHDATE (DD/MM/YY): __________ SEX/GENDER: __________ HEIGHT/WEIGHT: __________

SCHOOL/OCCUPATION: ____________________

HOME ADDRESS (Nº, STREET, CITY, PROVINCE): ____________________

____

POSTAL CODE: __________ HOME PHONE: __________ OTHER PHONE: __________

CONTACT EMAIL: ____________________

May we leave a voicemail regarding your appointment at these numbers? Yes ☐ No ☐

Are you likely to be available on short notice for future appointments or changes? Yes ☐ No ☐

We would like to send you email and text communications which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us. ☐

IN CASE OF EMERGENCY NOTIFY: ____________________

RELATION: ____________________ PHONE: __________

FAMILY PHYSICIAN: ____________________ PHONE: __________

NAME OF MEDICAL SPECIALIST: __________ AREA OF SPECIALTY: __________

PHONE OR ADDRESS: ____________________

NAME OF MEDICAL SPECIALIST: __________ AREA OF SPECIALTY: __________

PHONE OR ADDRESS: ____________________

PARENT/GUARDIAN/CAREGIVER 1 INFORMATION

NAME (SURNAME, GIVEN): ____________________

RELATION: ____________________

ADDRESS (Nº, STREET, CITY, PROVINCE): ____________________ PHONE: __________

OCCUPATION: ____________________ WORK PHONE: __________

PARENT/GUARDIAN/CAREGIVER 2 INFORMATION (IF DIFFERENT THAN ABOVE)

NAME (SURNAME, GIVEN): ____________________

RELATION: ____________________

ADDRESS (Nº, STREET, CITY, PROVINCE): ____________________ PHONE: __________

OCCUPATION: ____________________ WORK PHONE: __________

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PATIENT NAME: ______________________

PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE

(E.G. SCHEDULING APPOINTMENTS)

NAME: ______________________ RELATION: ______________________

HOW DID YOU HEAR ABOUT US?

- ☐ Friend
- ☐ Family member
- ☐ Colleague
- ☐ Staff member at our office
- ☐ Patient at our office
- ☐ Referral from health professional
- ☐ Website/Internet
- ☐ Advertisement
- ☐ Saw sign/Office in person
- ☐ Other: ______________________

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

______________________ ______________________

Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING)

SUBSCRIBER: ______________________

RELATION: ______________________

INSURANCE CO: ______________________

POLICY PLAN #: ______________________

DIVISION/SECT.#: ______________________

SUBSCRIBER ID: ______________________

SUBSCRIBER: (SECONDARY) ______________________

RELATION: ______________________

INSURANCE CO: ______________________

POLICY PLAN #: ______________________

DIVISION/SECT.#: ______________________

SUBSCRIBER ID: ______________________

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PATIENT NAME: ____________________

PATIENT DENTAL HISTORY

1. Reason for today's visit: ____

____

2. Do you have a dental problem that needs to be addressed as soon as possible? .... Yes ☐ No ☐
3. Have you been visiting the dentist regularly? .... Yes ☐ No ☐
4. Last dental visit ____________ Cleaning ____________ X-rays ____________
5. How often do you brush your teeth? ____________ Floss your teeth? ____________
6. Do your gums bleed regularly? .... Yes ☐ No ☐
7. Are your teeth sensitive to .... Hot ☐ Cold ☐ Biting ☐ Sweets ☐ Sour ☐ N/A ☐
8. Do you feel any pain in your teeth? .... Yes ☐ No ☐
9. Have you ever had any head, neck, or jaw injuries/surgery? .... Yes ☐ No ☐
10. Do you have dry mouth or difficulty swallowing? .... Yes ☐ No ☐
11. Do you snore or have sleep apnea? .... Yes ☐ No ☐
12. Does your jaw crack, click or pop when opened widely? .... Yes ☐ No ☐
13. Do you grind or clench your teeth during the day or night? .... Yes ☐ No ☐
14. Do you bite your lips/cheeks frequently? .... Yes ☐ No ☐
15. Have you ever experienced any growths, lumps or sore spots in your mouth? .... Yes ☐ No ☐
16. Have you noticed any loosening/movement of your teeth? .... Yes ☐ No ☐
17. Have you had periodontal (gum) treatment? .... Yes ☐ No ☐
18. Have you had orthodontic (braces) treatment? .... Yes ☐ No ☐
19. Have you ever had treatment by a dental specialist? .... Yes ☐ No ☐
20. Have you had previous problems with dental treatment? .... Yes ☐ No ☐
21. Are you satisfied with the appearance of your teeth? .... Yes ☐ No ☐
22. Are you nervous/anxious/fearful during dental treatment? .... Yes ☐ No ☐
23. Please list any other information that you feel we should have to provide you with the best possible dental care:

____

____

____ ____________________
Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

____ ____________________
Reviewed By Dentist Date

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PATIENT NAME: ______________________

MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

1. Do you have any health problems? .... Yes ☐ No ☐
   If yes, please provide details: ______________________

2. Has there been any change in your general health or weight in the past year? .... Yes ☐ No ☐
   If yes, please explain: ______________________

3. Are you currently being treated for any medical condition or have been treated in the last year? .... Yes ☐ No ☐
   If yes, please explain: ______________________

4. When was the last time you had a medical examination? ______________________
   Were any problems identified? .... Yes ☐ No ☐
   If yes, please explain: ______________________

5. Have you ever been hospitalized for any illnesses or operations? .... Yes ☐ No ☐
   If yes, please provide details: ______________________

6. Are you taking any medications, non-prescription drugs, homeopathic or herbal supplements, or hormones of any kind? .... Yes ☐ No ☐
   If yes, please list and provide reason for taking: ______________________

7. Do you have any allergies or reactions? .... Yes ☐ No ☐
   If yes, please list using the categories below:
   Medications ______________________
   Latex/rubber derived products ______________________
   Other (e.g. seasonal, foods, dyes) ______________________

8. Have you had an adverse reaction to any dental materials, injections or local anaesthetic? .... Yes ☐ No ☐
   If yes, please explain: ______________________

9. Do you have or have you ever had a replacement or a repair of a heart 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. Have you been advised to take pre-medication (e.g. antibiotics) prior to dental treatment? .... Yes ☐ No ☐
    If yes, please explain: ______________________

11. Do you have a prosthetic or artificial joint? .... Yes ☐ No ☐
    If yes, please provide details: ______________________

MEDICAL HISTORY CONTINUED ON NEXT PAGE

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PATIENT NAME: ______________________

MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

12. Do you have any conditions or have undergone therapies that could affect your immune system? .... Yes ☐ No ☐
    (Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)
    If yes, please explain: ______________________

13. Have you ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders? .... Yes ☐ No ☐
    If yes, please explain: ______________________

14. Do you have a bleeding problem, bleeding disorder, bruising tendency, or have had a blood transfusion? .... Yes ☐ No ☐
    If yes, please explain: ______________________

15. Do you have any or have you ever had any of the following (check all that apply): .... Yes ☐ No ☐

- ☐ Fainting/Dizzy spells
- ☐ Eating disorder
- ☐ Stroke/TIA
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Asthma or Emphysema
- ☐ Pacemaker
- ☐ Lung disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Steroid therapy
- ☐ Diabetes
- ☐ Stomach ulcers
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Arthritis/Rheumatism
- ☐ Seizures/Epilepsy
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Hyper/Hypoglycemia
- ☐ Mental or Nervous disorder
- ☐ Circulatory problems
- ☐ Blood transfusion
- ☐ Other communicable disease/ Transmissible infection
- ☐ Chest pain/Angina/Heart attack
- ☐ Drug/Alcohol/Cannabis use or dependency
- ☐ Shortness of breath
- ☐ Osteoporosis

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? .... Yes ☐ No ☐
    (e.g. diabetes, cancer, or heart disease)

18. Do you smoke, vape, use e-cigarettes or chew tobacco products? .... Yes ☐ No ☐

19. Are you pregnant? .... Yes ☐ No ☐
    If yes, what is the expected delivery date: ______________________

20. Are you breastfeeding? .... Yes ☐ No ☐

MEDICAL HISTORY CONTINUED ON NEXT PAGE

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MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

21. Do you identify as a person with a disability? .... Yes ☐ No ☐
    If yes, please explain: ______________________
    ____
22. Have you recently travelled to areas where endemic diseases are present? .... Yes ☐ No ☐
23. Have you recently experienced any new symptoms such as a cough, fever, chills, vomiting, diarrhea, rash or other illness since recent travel or otherwise? .... Yes ☐ No ☐
24. Have you had a recent exposure to a communicable infectious disease? .... Yes ☐ No ☐
    (e.g. measles, chicken pox or tuberculosis)
25. Have you recently received antimicrobial therapy? .... Yes ☐ No ☐
    If so, for what reason? ______________________
    ____
26. Are your immunizations up to date? .... Yes ☐ No ☐
27. Is there any additional information related to your health that has not been addressed above? .... Yes ☐ No ☐
    If so, please advise: ______________________
    ____

______________________ ______________________
Signature PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

______________________ ______________________
Reviewed By Dentist Date