# Welcome to Just Dental Care

**We appreciate the confidence you place with us to provide your dental services.**

All information provided in this form will remain confidential. The dental administration staff is available to help you complete any portion of this form. Full completion of the forms will allow us to provide you with the highest standard of dental care. Thank you for your co-operation.

Date (DD/MM/YYYY): _____/_____/_____ Medical Alert: _____

## Personal Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Email Address: _____ Primary Phone Number: _____

Emergency Contact: (Name & Relationship) _____ (Number)_____

Medical Doctor: _____ Phone: _____

Insurance Company Name: _____ Phone: _____

ID No.: _____ Policy No.: _____

Secondary Insurance Company: _____

ID No.: _____ Policy No.: _____

Who may we thank for referring you? _____

## Dental History

When was your last dental visit _____ Last X-rays _____

How frequently do you see a dentist □3-6 months □Annually □Other _____

Are your teeth sensitive to: □ Hot □ Cold □ Sweets □ No

Do your gums feel swollen and tender? □Yes □No

Do your gums bleed when: □ Brushing □ Flossing □ No Bleeding

History of any periodontal therapy □Yes □No

Do you grind or clench your teeth? □Yes □No

Does your jaw pop or crack when opening widely? □Yes □No

Have you had any prolonged bleeding following an extraction? □Yes □No

Do you have any sores or lumps in or near your mouth? _____

Are you satisfied with your teeth? □Yes □No _____

Have you ever had any problems/Anxiety with previous dental treatments? □Yes □No

**What can we do to make you smile?**

| | | |
|---|---|---|
| □ Teeth Whitening | □ Gummy Smile | □ Sleep Apnea/ Snoring |
| □ White Fillings | □ Orthodontic Treatment | □ Dental Implants |
| □ Replace Metal Fillings | □ Total Smi6le Makeover | □ Cosmetic Dentures |
| □ Eliminate Gaps | □ Broken/ Cracked Teeth | □ Gum Laser Treatment |
| □ Symmetrical Smile | □ Veneers | □ Neuromuscular Dentistry |
| □ Correct Misaligned Teeth | □ Replace Missing Teeth | □ Oral Conscious Sedation |

## Medical History – A Holistic Approach

Dental professionals primarily treat the area in and around your mouth, but since your mouth is part of your body, any medication you are taking, and your health history have an important relationship with your Dental Treatment. Please answer the following questions.

Are you under a physicians care right now? □Yes □No

_____

Have you been hospitalized or had a major operation? □Yes □No

_____

Have you ever had a serious head or neck injury/ concussion? □Yes □No

_____

Do you use any form of tobacco or nicotine? □Yes □No

If yes, how many cigarettes per day _____

How many units of alcohol do you consume per week (1/2-pint beer = 1 unit): _____

List any Medications you are currently taking: _____

Are you on birth control pills? □Yes □No

Are you or could you be pregnant or nursing? □Yes □No

If pregnant, what is the expected delivery date _____

Please go over the following section and indicate which of the following you have or have had. If you need to add further information, please enter it at the end.

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Cortisone Medicine | Yes | No | Hepatitis A | Yes | No | Radiation Treatments | Yes | No |
| Alzheimer's Disease | Yes | No | Diabetes | Yes | No | Hemophilia | Yes | No | Recent Weight Loss | Yes | No |
| Anaphylaxis | Yes | No | Drug Addiction | Yes | No | Hepatitis B or C | Yes | No | Renal Dialysis | Yes | No |
| Anemia | Yes | No | Easily Winded | Yes | No | Herpes | Yes | No | Rheumatic Fever | Yes | No |
| Angina | Yes | No | Emphysema | Yes | No | High Blood Pressure | Yes | No | Rheumatism | Yes | No |
| Arthritis/Gout | Yes | No | Epilepsy or Seizures | Yes | No | High Cholesterol | Yes | No | Scarlet Fever | Yes | No |
| Artificial Heart Valve | Yes | No | Excessive Bleeding | Yes | No | Hives or Rash | Yes | No | Shingles | Yes | No |
| Artificial Joint | Yes | No | Excessive Thirst | Yes | No | Hypoglycemia | Yes | No | Sickle Cell Disease | Yes | No |
| Asthma | Yes | No | Fainting Spells/Dizziness | Yes | No | Irregular Heartbeat | Yes | No | Sinus Trouble | Yes | No |
| Blood Disease | Yes | No | Frequent Cough | Yes | No | Kidney Problems | Yes | No | Spina Bifida | Yes | No |
| Blood Transfusion | Yes | No | Frequent Diarrhea | Yes | No | Leukemia | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Breathing Problem | Yes | No | Frequent Headaches | Yes | No | Liver Disease | Yes | No | Stroke | Yes | No |
| Bruise Easily | Yes | No | Genital Herpes | Yes | No | Low Blood Pressure | Yes | No | Swelling of Limbs | Yes | No |
| Cancer | Yes | No | Glaucoma | Yes | No | Lung Disease | Yes | No | Thyroid Disease | Yes | No |
| Chemotherapy | Yes | No | Hay Fever | Yes | No | Mitral Valve Prolapse | Yes | No | Tonsillitis | Yes | No |
| Chest Pains | Yes | No | Heart Attack/Failure | Yes | No | Osteoporosis | Yes | No | Tuberculosis | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Heart Murmur | Yes | No | Pain in Jaw Joints | Yes | No | Tumors or Growths | Yes | No |
| Congenital Heart Disorder | Yes | No | Heart Pacemaker | Yes | No | Parathyroid Disease | Yes | No | Ulcers | Yes | No |
| Convulsions | Yes | No | Heart Trouble/Disease | Yes | No | Psychiatric Care | Yes | No | Venereal Disease | Yes | No |

Please enter details or any further information.

_____

_____

Are you **allergic** to or have you had a reaction to any of the following?

☐None ☐Aspirin ☐Codeine

☐Sulfa Drugs ☐Penicillin ☐Acrylic

☐Latex/rubber products ☐Metal

☐Other _____

Is there anything else you would like to mention that has not been covered in this form?

_____

_____

Do you have any requests to make your visits more comfortable?

_____

_____

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

**Signature of patient, parent, or guardian: _____Date_____**

**Dentist/Hygienist: _____Date_____**