Winona DENTAL

PATIENT MEDICAL & DENTAL HISTORY

PATIENT INFORMATION

First Name: Last Name:

Date of Birth: DD / MM / YY Postal Code: Phone:

DENTAL HISTORY

Please answer the following questions.

1. Are you currently experiencing any discomfort?

2. Primary reason for today's visit:

2.b. Your last visit to the dentist was:

3. How frequently do you visit the dentist in a year?

4. Level of dental nervousness? *1 (low) - 10 (high)*

5. When were your last dental x-ray taken?

b. If appropriate, would you like us to request your previous x-rays?

6. How frequently do you brush your teeth?

b. How frequently do you floss your teeth?

7. Who was your last dentist?

b. How long were you a patient of theirs?

8. Why have changed dentist?

9. Do you have any of the following? *(Please check all applicable boxes)*

Tooth sensitivity to:

- ☐ Cold
- ☐ Hot
- ☐ Sweet
- ☐ Pressure
- ☐ Orthodontic treatment
- ☐ Clenching or grinding of teeth
- ☐ Jaw joint sound/pain
- ☐ Gag easily
- ☐ Difficulties opening
- ☐ Periodontal (gum) treatment
- ☐ Pain in ears
- ☐ Dry mouth
- ☐ Loose or shifting teeth
- ☐ Frequent canker / cold sores
- ☐ Bad breath or taste
- ☐ Tired jaw
- ☐ Swelling in mouth
- ☐ Frequent headaches
- ☐ Favour one side of your mouth when you eat
- ☐ Bleeding gums

If so how often?

Oral Habits:

- ☐ Mouthbreathing
- ☐ Biting, chewing, holding object in mouth
- ☐ Clenching when nervous or upset
- ☐ Lip biting

Others:

10. Are there any aspects of your smile that you would like to improve?

11. Have you ever had any unpleasant experiences in a dental office? Explain.

12. Any particular concerns or preference that we should be aware of regarding your dental care or treatment?

13. Any aspect of dentistry you would like more information about?

MEDICAL HISTORY *Please answer the following questions.*

1. Are you being treated for any medical conditions at the present or have you been treated within the past year?

☐ Yes Why? _____ ☐ No ☐ Maybe

2. When was your last medical checkup?

3. Has there been any changes in your general health in the past year?

☐ Yes Explain. _____ ☐ No ☐ Maybe

4. Please list any medications, non prescription drugs or herbal supplements of any kind that you are taking:

5. Do you have any allergies?

☐ Yes ⌐ If yes, please indicate below: ¬ ☐ No ☐ Maybe

a. Medications.

☐ Penicillin ☐ Sulpha ☐ ASA ☐ Codeine ☐ Erythromycin ☐ Anesthetics

Others: _____

b. Latex/Rubber products

c. Others (e.g. hay fever, foods, metals)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections?

☐ Yes Explain. _____ ☐ No ☐ Maybe

7. Have you ever been advised to take antibiotics prior to dental treatment?

☐ Yes Explain. _____ ☐ No ☐ Maybe

8. Do you have or have you ever had asthma?

☐ Yes ☐ No ☐ Maybe

9. Do you have any heart or blood pressure problems?

☐ Yes ☐ No ☐ Maybe

10. Do you have anemia, bruise easily, bleeding problem or bleeding disorder?

☐ Yes ☐ No ☐ Maybe

11. Do you have a prosthetic or artificial joint? (heart valves, hip, joint, pacemaker)

☐ Yes ☐ No ☐ Maybe

12. Have you ever been hospitalized for any illnesses or operations/surgery?

☐ Yes Explain. _____ ☐ No ☐ Maybe

13. Do you have any conditions or therapies that could affect your immune system? (leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)

☐ Yes ☐ No ☐ Maybe

14. Have you ever had a heart, replacement/repair of a valve, infection (i.e. infective endocarditis), condition from birth (i.e. congenital heart disease), transplant?

☐ Yes ☐ No ☐ Maybe

15. Have you ever had hepatitis, jaundice or liver disease?

☐ Yes ☐ No ☐ Maybe

16. Have you ever been told you should not give blood?

☐ Yes ☐ No ☐ Maybe

17. Do you have or have you ever had any of the following? *(Please check all applicable boxes)*

☐ Arthritis	☐ Emphysema	☐ Shortness of Breath	☐ Herpes
☐ Digestive Disorders	☐ Sinus Problems	☐ Cancer	☐ Diabetes
☐ Nervous Problems	☐ Lung disease	☐ Heart attack	☐ Glaucoma
☐ Seizures (Epilepsy)	☐ Chest Pain, Angina	☐ Heart Surgery	☐ Steroid Therapy
☐ Head or Neck Injuries	☐ Mitral Valve Prolapse	☐ Rheumatic Fever	☐ Tuberculosis
☐ Psychiatric Disorders	☐ Kidney Disease	☐ Antidepressants	☐ Headaches
☐ Heart Murmur	☐ Drug/Alcohol Dependency	☐ Stomach Ulcers	☐ Stroke

☐ Osteoporosis Medication (e.g. Fosamax, Actonel)

18. Are there any conditions or diseases not listed above that you have or have had?

☐ Yes Explain. _____ ☐ No ☐ Maybe

19. Are there any diseases or medical problems that run in your family? (e.g. diabetes, heart disease etc.)

☐ Yes ☐ No ☐ Maybe

20. Do you smoke or chew tobacco products?

☐ Yes ☐ No ☐ Maybe

21. Do you take recreational drugs?

☐ Yes ☐ No ☐ Maybe

22. Are you nervous during dental treatments?

☐ Yes ☐ No ☐ Maybe

23. *For women only:* Are you breastfeeding or pregnant?

☐ Yes If pregnant, what is expected delivery date? _____ ☐ No ☐ Maybe

I hereby consent to all dental and oral surgery procedures performed in this office including the use of nitrous oxide, x-rays and/or relevant anaesthesia as indicated. I also give consent to photos being taken of me and used for treatment planning and patient education.

I understand that the fees are in accordance with the current Ontario Dental Association suggested fee guide, and I assume all responsibilities for any fees associated with the dental services provided by Winona Dental, the registered business name of Dr. Samantha Wong Dentistry Professional Corporation, Dr. Wong and staff. I authorize my insurance claims to be submitted electronically where applicable, and understand that full payment is required at the time of service, unless prior arrangements have been approved. I understand that when appointments are scheduled, staff and facilities are reserved for me and that at least 2 business days notice is required for any changes to my appointment, or a fee may be applied to my account.

I also consent to your collection, of any and all personal information about me including personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relating to, your dental practice. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or part of any treatment or service you provide.

Signature of Patient/Parent/Guardian: Parent/Guardian Name: Date:

_____ _____ _____

Signature of Dentist: Date:

_____ _____

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