

# Welcome To Our Dental Office

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION ON BOTH SIDES.

## PERSONAL INFORMATION

Date \_\_\_\_\_  
 Day                      Month                      Year

Name \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ Home Phone \_\_\_\_\_

Postal Code \_\_\_\_\_ Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Occupation \_\_\_\_\_ Title: Mr. / Miss / Mrs. / Ms.

Name of Employer \_\_\_\_\_ Medical Doctor \_\_\_\_\_

Email \_\_\_\_\_

Name of person responsible for this account \_\_\_\_\_

Do you have dental insurance? \_\_\_\_\_

Company Name \_\_\_\_\_

Policy No. \_\_\_\_\_ % Covered \_\_\_\_\_

I.D. or S.I.N. No. \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

## MEDICAL HISTORY

**Yes**      **No**

1. Have you ever had a serious illness, operation, or been hospitalized?

If Yes, explain \_\_\_\_\_

2. Are you under the care of a physician now for any problem?

If Yes, explain \_\_\_\_\_

3. Have you had a medical examination within the last year?

If Yes, explain \_\_\_\_\_

4. Have you taken any medicines, drugs or pills presently?

If Yes, explain \_\_\_\_\_

5. Have you ever taken or been given bisphosphonate medication or any of its family?

6. Do you have or have you ever had any of the following? (Circle)

- |                           |                                     |                 |
|---------------------------|-------------------------------------|-----------------|
| Rheumatic Fever           | Liver Disease (Jaundice, Hepatitis) | Thyroid Disease |
| Heart Trouble             | Kidney Disease                      | Lung Disease    |
| High Blood Pressure       | Diabetes                            | Asthma          |
| Heart Murmur              | Epilepsy                            | Blood Disorders |
| Venereal Disease          | Radiation or X-ray Disease          | Anemia          |
| Mental or Nervous Disease | Gastrointestinal Disease            | Cancer          |
| Joint Replacement         | AIDS                                | Sinusitis       |

Other \_\_\_\_\_

7. Do you have any allergies?

If Yes, explain \_\_\_\_\_

8. Are you allergic to any medicines or drugs?

If Yes, explain \_\_\_\_\_

- |                                                                                                                                 | <b>Yes</b>               | <b>No</b>                |
|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 9. Have you ever had freezing (local anaesthetic) in your mouth?<br>Any ill effects from it? _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you bleed abnormally?                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you bruise easily?                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever fainted? When? _____                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have shortness of breath?                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have any chest pains?                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do your ankles ever swell?                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you gained or lost excessive weight recently?                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever taken cortisone or steroids?                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Is there any history of family disease?                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Is there anything that the dentist should know regarding your medical history that has not been mentioned?<br>Explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. To the best of your knowledge, are you in good health?                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| WOMEN: Are you pregnant?<br>If yes, in what stage of pregnancy? _____                                                           | <input type="checkbox"/> | <input type="checkbox"/> |

## DENTAL HISTORY

1. Have you ever had a complete dental examination with a full series of dental x-rays within the past 3 years?
2. Last dental visit? \_\_\_\_\_ What was done? \_\_\_\_\_
3. Have you had any extractions?    
If yes, did you experience prolonged bleeding after?
4. Have you ever had any of the following dental treatments? (Circle)
 

Root Canal	Orthodontics	Full or partial denture
Periodontal (gums)	Crowns or Caps	Bridgework
5. Are you aware of bad breath or a bad taste in your mouth?
6. Have you ever had a bad experience at the dentist?
7. What is your present dental problem? \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT/GUARDIAN APPROVAL AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

I also consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume the responsibility for fees associated with these procedures.

Signature \_\_\_\_\_ Date \_\_\_\_\_



# MAPLEVIEW FAMILY DENTISTRY

*The dental office for the entire family!*

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**Email Address:** [info@maplevuefamilydentistry.com](mailto:info@maplevuefamilydentistry.com)

## TRANSFER & X-RAY RELEASE FORM

Date: \_\_\_\_\_

The following patients:

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

5. \_\_\_\_\_  
6. \_\_\_\_\_

Authorize the release of records, x-rays, and any other pertinent information from:

\_\_\_\_\_  
(Name of Previous Dental Office)

To my new dental office whose name and address appears above.

Signature: \_\_\_\_\_

**FOR OFFICE USE ONLY!** Please provide the following information for each person(s).

Name & Date	Complete Exam	Recall Exam	Full Mouth Series	Panorex	Bitewings

Please send response back via fax and copies of digital radiographs can be emailed.

Thank you kindly,

Maplevue Family Dentistry