| ToothToothWELCOME TO HAMPTON PARK DENTAL CENTRE  Puzzled about your dental care? Let us put the pieces together for you! |
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| REGISTRATION INFORMATION This information will enable us to maintain communication with you.  Is this patient an: Adult: \_\_\_\_ Child: \_\_\_\_ Adult Under Guardianship(Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name: DR. MR. MRS. MS. MISS (LAST)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(FIRST)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prefers to be called\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt.\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Province\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bus. Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Additional Phone(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we call you at work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M\_\_\_\_\_\_F\_\_\_\_\_\_ Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Spouse’s Name/Other Family Members\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred Appt Time (AM/PM) \_\_\_\_\_\_\_\_\_\_\_Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for today’s visit? Exam\_\_\_\_\_\_\_\_\_\_\_ Emergency\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is there a dental problem you would like treated immediately? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| FINANCIAL INFORMATION This information is necessary to process invoices and apply payments.  Person responsible for account: SELF\_\_\_\_\_\_\_ SPOUSE\_\_\_\_\_\_\_ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *PLEASE COMPLETE ALL INFORMATION ONLY IF DIFFERENT THAN ABOVE*  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DENTAL INSURANCE INFORMATION  Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy/Plan Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Certificate/ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  IS THERE A SECONDARY INSURANCE PROVIDER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| MEDICAL HISTORY Please answer yes to any question that applies. If unsure, please consult with the dentist.  1. Are you being treated for any medical condition at present, or within the past two years? If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. Have you been hospitalized within the last two years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Have you recently seen your family physician? \_\_\_\_\_\_\_\_Last complete physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Have you recently or are you currently taking any prescription medication? \_\_\_\_\_\_\_\_\_\_Non-Prescription? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please list: (include herbal remedies, SPECIFICALLY FISH OIL, VITAMIN C, VITAMIN E) 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  5. Have you ever reacted adversely to any medication or injection? \_\_\_\_\_\_\_\_\_\_\_\_Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please circle if yes: Penicillin Other Antibiotics Aspirin Codeine Local Anaesthetic Nitrous Oxide  6. Have you ever been advised against taking any specific type of medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  7. Do you have any of the following? Please Circle: Food Allergies Hives Metal or Latex Allergies Asthma Hay Fever Skin Rashes Any other allergic conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  8. Do any of these allergic conditions result in the following? Headache Swelling Shortness of Breath Chest Constriction Nausea Other If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  9. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  10. Do your hands, feet or ankles swell? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  11. Has your weight, appetite or energy level changed dramatically recently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  12. Do you follow a special diet, or diet pill therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  14. Do you have FREQUENT, SEVERE headaches, earaches, ear/throat infections? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  15. Have you ever had any injury or surgery to your face or jaw? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  16. Do you wear eyeglasses or contact lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  17. Do you have any hearing difficulties? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  18. Do you smoke or use any other forms of tobacco? \_\_\_\_\_ Are you wearing a transdermal Nicotine Patch? \_\_\_\_ Do you have a Marijuana Prescription? \_\_\_\_\_Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  19. Are you alcohol and/or drug dependent? \_\_\_\_\_\_\_\_\_Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  20. Have you received treatment for alcohol or drug related issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  21. Do you use any substances recreationally? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR HAVE EVER HAD**

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|  | Yes | No | Condition | Yes | No | Condition | Yes | No |
| HIV/AIDS |  |  | **Glaucoma** |  |  | **Lung Disease** |  |  |
| Anemia |  |  | **Head/Neck Injuries** |  |  | **Lupus** |  |  |
| Angina |  |  | **Heart Disease/Attack** |  |  | **Medical Implant** |  |  |
| Arthritis/Rheumatism |  |  | **Heart Murmur** |  |  | **Mental Disorder** |  |  |
| Artificial Heart Valve |  |  | **Heart Pacemaker** |  |  | **Organ Transplant** |  |  |
| Artificial Joint ie. Hip, Knee |  |  | **Heart Rhythm Disorder** |  |  | **Osteoporosis** |  |  |
| Bronchitis |  |  | **Heart Surgery** |  |  | **Radiation/Chemo** |  |  |
| Cancer |  |  | **Hepatitis A B C** |  |  | **Rheumatic Fever** |  |  |
| Circulation Problems |  |  | **Herpes** |  |  | **Scarlet Fever** |  |  |
| Crohn’s Disease/IBS |  |  | **High/Low Blood Pressure** |  |  | **Sinus Trouble** |  |  |
| Diabetes |  |  | **Hyper/Hypo Glycemia** |  |  | **Gastro Intestinal Problems** |  |  |
| Emphysema |  |  | **Hypertension** |  |  | **Stroke** |  |  |
| Epilepsy/Seizures |  |  | **Jaundice** |  |  | **Thyroid Disease** |  |  |
| Fainting/Dizzy Spells |  |  | **Kidney Disease** |  |  | **Tuberculosis** |  |  |
| Glandular Disorders |  |  | **Liver Disease** |  |  | **Venereal Disease** |  |  |

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| **23. FOR THE CHILD PATIENT ONLY**  **Has the child patient recently had any of the following? If so, please indicate date:**  **Measles\_\_\_\_\_\_\_\_\_\_ Mumps\_\_\_\_\_\_\_\_\_\_ Chicken Pox\_\_\_\_\_\_\_\_ Strep Throat \_\_\_\_\_\_\_\_\_\_Tonsillitis\_\_\_\_\_\_\_\_\_\_\_** |

**24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? \_\_\_\_**

**Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**26. Do you wish to speak privately to the Dentist about any problem or medical condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **27. WOMEN ONLY**  **Are you pregnant or suspect you may be? \_\_\_\_\_ Expected delivery date? \_\_\_\_\_\_\_ Are you currently breast feeding? \_\_\_\_\_\_**  **Are you taking birth control pills? \_\_\_\_\_ Do you have a birth control implant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **DENTAL HISTORY** Please answer yes or no to the following questions. If unsure of a question, please consult with the Dentist.  **Is there a problem you would like treated immediately? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_ Last dental hygiene appointment? \_\_\_\_\_\_\_\_\_\_\_ Last xrays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **1. Have you been seeing a dentist regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **2. Have you ever had any of the following? Periodontal Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Orthodontic Treatment? \_\_\_\_\_\_\_\_\_\_**  **A bite plate or nightguard? \_\_\_\_\_\_\_\_\_\_\_\_\_ Your bite adjusted? \_\_\_\_\_\_\_\_\_\_\_\_\_ Oral surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **3. Are there any growths or sore spots in your mouth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **4. Do your gums bleed while brushing or eating, do your gums swell? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **5. Have you noticed any loose teeth or have your teeth shifted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **6. Does food catch between your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **7. Are any of your teeth sensitive to hot/cold, sweets or pressure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **8. Have you been advised to take antibiotics before a dental appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **9. Do you use dental floss, stimudents or proxabrush? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **10. How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you feel you have bad breath? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **11. Have you ever experienced any of the following jaw problems: Popping/Clicking in your jaw joint\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Pain in your jaw joint, around your ear or side of face\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Difficulty opening or closing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Pain when teeth are clenched\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pain or difficulty when chewing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **12. Do you have any of the following habits:**  **Clenching or grinding, while awake or asleep\_\_\_\_\_\_\_\_\_\_ Biting cheeks or lips \_\_\_\_\_\_\_\_\_\_\_Mouth Breathing\_\_\_\_\_\_\_\_\_\_\_\_**  **Placing foreign objects in mouth (pins, pipes, pens, biting fingernails) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **13. Do you have any emotional concerns/anxiety about having dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have and questions or concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **15. Are you unhappy with the appearance of your teeth ie. colour, positioning, spaces? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **16. Do you feel that your dental health influences your overall health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **17. On a scale of 1 to 10, 10 being highest, how important is it to you to keep your natural teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| | **GENERAL RELEASE**  I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical/dental history. **Should there be any changes in either my health status or any other information I have provided, I will advise the Hampton Park Dental Centre.** I authorize Dr. Crossman to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health provider may be necessary. I have been advised of the privacy policy of the Hampton Park Dental Centre and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.  **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PATIENT, PARENT OR GUARDIAN (signature)**  **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PRINT NAME OF GUARDIAN**  **Reviewed by treating dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | --- | |