Patient Information

CHART ID *(Office use only)*

First Name: _____ Last Name: _____ Birth Date: _____ Age: _____

Address: _____ Employer: _____
Street City/Province/Postal Code

Home #: _____ Work #: _____ Cell #: _____

Email: _____ How did you hear of our clinic or whom were you referred by? _____

Medical History

Physician's Name: _____ Physician's Phone: _____

GENERAL	Yes	No
Have you/have you ever had:		
1. Been examined and/or treated by a physician within the last year?		
2. Been hospitalized for illness or injury?		
3. Major surgery?		
4. Pre-medication prior to dental appts?		
5. Radiation therapy?		
6. Immunosuppressive or chemotherapy?		
Are you:		
7. Presently being treated for another illness?		
8. Aware of a change in your health in the last 24 hours (i.e., fever, chills, cough, diarrhea)?		
9. A smoker (previous or current)?		

SENSITIVITIES AND/OR ALLERGIES	Yes	No
Do you have/have you ever had:		
1. Hives, skin rash?		
2. Asthma?		
3. Hay fever?		
Have you had unusual reactions to:		
☐ Dental anesthesia (freezing)?		
☐ Aspirin, ibuprofen, acetaminophen?		
☐ Penicillin?		
☐ Sulfa?		
☐ Fluoride?		
☐ Latex?		
☐ Metals (e.g., nickel, gold, silver)?		
☐ Other:		

SPECIFIC	Yes	No
Do you have/have you ever had:		
1. HIV/AIDS?		
2. A pacemaker or implantable defibrillator?		
3. An artificial heart valve or repaired heart defect (e.g., PFO)?		
4. Stroke?		
5. Rheumatic fever?		
6. Arthritis or lupus?		
7. Hepatitis?		
8. Tuberculosis, measles, or chickenpox?		
9. A mental health condition?		
10. A nutritional/eating disorder?		
11. An STI/STD?		
12. Use street drugs or heavy alcohol?		
13. **FEMALES** - Are you pregnant?		
14. **FEMALES** - Are you taking birth control pills?		
15. **MALES** - Do you have a prostate disorder?		

SYSTEMS REVIEW	Yes	No
Neurologic/ENT		
Do you have:		
1. Epilepsy or seizures?		
2. Severe headaches?		
3. Eye or vision issues?		
4. Frequent colds?		
5. Sinus issues?		
6. Frequent nosebleeds?		
7. A sore throat?		
8. Earaches?		
Hematologic		
Do you:		
9. Bleed a long time after an injury?		
10. Bruise easily?		
11. Have anemia or a blood disorder?		
Cardiac/Respiratory		
Do you have:		
12. High or low blood pressure?		
13. High cholesterol?		
14. Shortness of breath episodes?		
15. Chest pains (angina)?		
16. Snoring or sleep problems (apnea)?		
Gastrointestinal		
Do you have:		
17. An ulcer?		
18. Digestive disorders (i.e., celiac disease, gastric reflex)?		
Endocrine/Metabolic		
Do you have:		
19. Diabetes?		
20. Liver disease?		
21. Thyroid or parathyroid issues, or calcium deficiency?		
22. Kidney disease?		

List all medications, supplements, and/or vitamins taken within the last two years.

Drug	Purpose

Patient Signature: _____ **Date:** _____

Dentist Signature: _____ **Date:** _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
34. Have you ever whitened (bleached) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

FIFTH AVENUE DENTAL

Office Policies

Welcome to Fifth Avenue Dental Centre! As your dental team we would like you to know that we are committed to providing you and your family high quality dentistry while maintaining a warm and welcoming atmosphere. To assist us maintaining this high quality of service we ask that you please observe the following guidelines.

Appointments and Cancellation Policy

Dental appointments are considered confirmed at the time of booking. This is time reserved especially for you with your dentist, assistant, or hygienist as well as the operatory space as required. We provide courtesy reminders via SMS and email.

Please take a moment to "confirm" your appointment through these courtesy reminders to avoid another phone call the day before your appointment.

We request that in order to meet our patient's dental needs you give the courtesy of **2 business days' notice** to make any changes to your reserved appointment time. Requests for changes to appointments are only accepted when calling the office during regular office hours.

Patients are asked to ensure they arrive on time to their appointment to prevent their appointment running into another patient's reserved time.

I prefer to receive courtesy reminders via:

☐ No reminders needed ☐ SMS ☐ Email ☐Telephone Call

Payment for Services

If you have dental insurance through your employer, spouse or parent it is important to understand that the insurance coverage is a contract between you, your employer, and the dental insurance company. Employers may make changes in the contracts and employees are not always made aware. While it appears there has been no change to your insurance, various clauses or restrictions may have been added which can reduce the amount the insurance company pays towards treatment. As we are a third party, it is impossible for us to have a complete understanding of your insurance. It is in your best interest to familiarize yourself with any restrictions in your plan towards treatment required.

We, at Fifth Avenue Dental will give you a proposal of treatment needed and the estimated cost associated with it. We do not diagnose treatment according to the type or limitations you have with your plan. We treat each patient as an individual, regardless of whether they have insurance or not, and if you have coverage for the treatment, it is only an added benefit to you. If your insurance refuses payment towards treatment, it does not under any circumstances mean that the treatment was or is not needed.

As part of our commitment to providing quality service, we at Fifth Avenue Dental are a non-assignment office. This means payment is collected from patients at the time of treatment. Our friendly staff are happy to assist you in filing any claim paperwork to assist you in reimbursement from your plan.

I hereby have read the contents of this letter and understand the terms.

_____ _____

Patient/Guardian signature Date