Patient Information

Name _____ Address _____
City _____ Province _____ Postal Code _____
Home Phone _____ Business Phone _____
Cell Phone _____ Email _____
❑ Married ❑ Single ❑ Divorced ❑ Widowed Birthdate _____

Account Information

Name of person responsible for this account _____
Employer _____ Occupation _____
Business Telephone _____ Ext._____ Fax _____

Dental Insurance	Primary Coverage	Secondary Coverage
Name of Insurance Company		
Group No		
Subscriber's I.D. No.		
Subscriber Name		
Subscriber Birthdate		
Union or Local No.		

Getting to know you

Is another member of your family a patient at this office? ❑ Yes ❑ No
If yes, what is their name? _____
Who may we thank for this referral? _____
Person to contact in case of emergency: Name _____ Tel. _____
Family Physician _____ Tel. _____
Medical Specialist (if applicable) _____ Tel. _____
Your spouse's name (if married) _____ Bus. Tel. _____
Your children's names _____

Information if patient is under 16 years old **Prefers to be called** _____
Name of school _____ Hobbies or interests _____
Other parent's name _____ Address, if different _____
Names of brothers or sisters _____
Has this child had any bad dental experiences ❑ Yes ❑ No comments _____

Patient's comments

Initial Clinical Examination

DATE _____

Date of last dental visit	Date of last check up and cleaning	Date of last X-rays

Do you have an immediate dental problem ❑ Yes ❑ No

A. Have you ever had:

Orthodontic Treatment ❑ Yes ❑ No

Oral Surgery ❑ Yes ❑ No

Periodontal Treatment ❑ Yes ❑ No

Your teeth ground or bite adjusted ❑ Yes ❑ No

A bite plate, night guard or other appliance ❑ Yes ❑ No

Are your teeth sensitive to hot, cold or sweets ❑ Yes ❑ No

Have you noticed any loosening of your teeth ❑ Yes ❑ No

Does food tend to become caught between your teeth ❑ Yes ❑ No

Do you suffer from pain and/or swelling of your gums ❑ Yes ❑ No

Do your gums bleed when you brush your teeth ❑ Yes ❑ No

Have you noticed any growths or sores in your mouth ❑ Yes ❑ No

Are you conscious of bad breath or unpleasant taste ❑ Yes ❑ No

B. Problems of the Jaw

Have you experienced:

Clicking of the jaw ❑ Yes ❑ No

Pain (joint, ear, side of face) ❑ Yes ❑ No

Difficulty in opening or closing ❑ Yes ❑ No

Difficulty in chewing ❑ Yes ❑ No

C. Habits

Do you:

Clench or grind your teeth while awake or asleep ❑ Yes ❑ No

Chew gum ❑ Yes ❑ No

Regularly use toothpicks ❑ Yes ❑ No

Frequently snack between meals ❑ Yes ❑ No

When and how often do you brush your teeth _____

Do you floss ❑ Yes ❑ No

How often _____

Are you nervous about coming to the dentist ❑ Yes ❑ No

Have you ever had an upsetting dental experience ❑ Yes ❑ No

Have you had any form of sedation for dental treatment ❑ Yes ❑ No

What shape do you think your teeth are in _____

Is it important to you to keep your teeth ❑ Yes ❑ No

What don't you like about your smile _____