Welcome to Thornhill Square Dentistry!

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

Patient Information A parent/guardian will be responsible for decisions on my treatment ▫ Yes ▫ No

Name: _____
First Initial Last

Address: _____
Street Apt City Prov. Postal Code

Date of Birth (D/M/Y): ___/____/_____ E-mail: _____

Home Tel. (_____) _____ Work Tel. (____)_____ Cell (____)_____

Emergency Contact: _____ Tel. (_____) _____

Family Doctor: _____ Tel. (_____) _____

How did you hear about us?

▫ Internet ▫ Friends & Family ▫ Flyers, Magazines, Sign ▫ Other _____

Financial Information

Method of payment: ▫ Cash ▫ Cheque ▫ Credit Card ▫ Insurance ▫ Other

Person responsible for financial matters: ▫ Self ▫ Spouse ▫ Parent/Guardian ▫ Other

IF DIFFERENT FROM ABOVE

Name: _____
First Initial Last

Address: _____
Street Apt City Prov. Postal Code

Date of Birth (D/M/Y): ___/____/_____ E-mail: _____

Home Tel. (_____) _____ Work Tel. (____)_____

Driver's Lis. _____ OR SIN #: _____

Health Card: _____

PRIMARY INSURANCE

Ins. Company: _____ Tel. (_____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy #: _____ Certificate #: _____ ID/SIN#: _____

Medical History (This information will remain confidential) YES NO

1. Are you presently under the care of a physician? If so, explain _____ ▫ ▫
2. Have you ever been hospitalized? Explain. _____ ▫ ▫
3. Are you taking any drugs or medications at this time? _____ ▫ ▫
   A) Drug _____ Reason _____
   B) Drug _____ Reason _____
   C) Drug _____ Reason _____
4. Have you ever had any adverse effect to any of the following?

Antibiotic – Penicillin ▫ Sulfamide ▫ Other ▫ _____

Aspirin ▫; **Barbiturates** (Sleeping pills) ▫; **Codeine** ▫; **Darvon** ▫; **Local Anesthetic** ▫; **NONE** ▫

5. Have you ever been warned against using any other medications? Which? _____ ▫ ▫

6. Have you ever taken prolonged medical or non-medical drugs? Which? _____ ▫ ▫

7. Do you suffer from any allergies (hay fever, latex, etc.)? Which? _____ ▫ ▫

8. Do you bruise easily or have prolonged bleeding? _____ ▫ ▫

9. Do you smoke? How much per day? _____ ▫ ▫

10. Have you ever fainted, had shortness of breath or chest pains? _____ ▫ ▫

11. **WOMEN** Are you pregnant? ▫ Yes ▫ No Using birth control? ▫ Yes ▫ No Reached Menopause? ▫ Yes ▫ No

12. Do you have or have you ever had any of the following? Please check the appropriate boxes. NONE ▫

- ▫ AIDS
- ▫ Anemia
- ▫ Angina pectoris
- ▫ Anorexia nervosa
- ▫ Artificial heart valve
- ▫ Artificial joints (hip, knees)
- ▫ Asthma
- ▫ Blood disorders
- ▫ Bronchitis
- ▫ Bulimia
- ▫ Cancer
- ▫ Circulation problems
- ▫ Congenital heart lesions
- ▫ Cortisone/steroid
- ▫ Diabetes
- ▫ Drug/alcohol dependence
- ▫ Emphysema
- ▫ Epilepsy
- ▫ Glandular disorder
- ▫ Glaucoma
- ▫ Head/neck injuries
- ▫ Heart disease/attack
- ▫ Heart murmur
- ▫ Heart pacemaker/ surgery
- ▫ Heart rhythm disorder
- ▫ Hepatitis A/B/C
- ▫ Herpes
- ▫ High/Low blood pressure
- ▫ HIV positive
- ▫ Hodgkin disease
- ▫ Hyper/Hypo Glycemia
- ▫ Hypertension
- ▫ Jaundice
- ▫ Kidney disease
- ▫ Liver disease
- ▫ Leukemia
- ▫ Lung disease
- ▫ Malignant hypothermia
- ▫ Mental/nervous disorder
- ▫ Mitral valve prolapse
- ▫ Organ transplant/ implant
- ▫ Psychiatric disorders
- ▫ Radiation/ chemotherapy
- ▫ Rheumatic/Scarlet fever
- ▫ Sickle Cell disease
- ▫ Stomach/intestinal problems
- ▫ Stroke
- ▫ Thyroid disease
- ▫ Tuberculosis
- ▫ Ulcers
- ▫ Venereal disease
- ▫ Other _____
- ▫ Other _____
- ▫ Other _____

13. CHILDREN Have you recently had any of the following (approximate date)?

▫	Chicken pox _____	▫	Strep Throat _____
▫	Measles _____	▫	Tonsillitis _____
▫	Mumps _____	▫	NONE

Dental History

1. What is the reason for today's visit? ▫ Emergency ▫ Examination ▫ Other _____
2. How frequently do you see the dentist? ▫ 3-6 months ▫ Annually ▫ Other _____
3. When was your last dental visit? _____ Last X-Ray? _____
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
5. Are your teeth sensitive to: ▫ Cold ▫ Heat ▫ Sweets ▫ Other _____
6. Do your gums bleed when: ▫ Brushing ▫ Flossing ▫ Never
7. Do your gums feel swollen or tender? _____
8. Do you have bad breath or a bad taste in your mouth? _____
9. Do your jaws crack, pop, or grate when you open widely? _____
10. Do you grind or clench your teeth? _____
11. DO you have food catch between your teeth? _____
12. Have you ever had local anaesthetic (freezing?) Any complications? ▫ Yes ▫ No ▫ Specify _____
13. Have you ever had any problems with previous dental treatments? ▫ Yes ▫ No ▫ Specify _____
14. Have you ever had any of the following?

	YES	NO
	▫	▫
	▫	▫
	▫	▫
	▫	▫
	▫	▫

- ▫ Bridgework
- ▫ Crowns or caps
- ▫ Orthodontic (braces)
- ▫ Periodontal (Gums)

15. Are you satisfied with your teeth? Specify _____

General Release

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care providers as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ▫ Patient ▫ Parent/Guardian Print Name Date