Dentist on Dundas

Welcome. In order to provide you with the best service, please fill out the following contact information and dental questionnaire.

If you have any questions, please ask a team member for assistance.

Contact Information

Last Name | First Name | Birthday (MM/DD/YYYY)

Street | Unit | City | Province | Postal Code

( ) | ☐ Phone ☐ E-Mail

Phone Number | E-Mail | Preferred contact

Who should we contact in case of emergency? | ( ) Phone Number

Name of family physician? | ( ) Phone Number

Dental Questionnaire

Please select all that apply to you.

- ☐ Cavities
- ☐ Lost Fillings
- ☐ Tooth Pain
- ☐ Wisdom Teeth
- ☐ Swelling
- ☐ Hot/Cold Sensitivity
- ☐ Discoloured Teeth
- ☐ Chipped Teeth
- ☐ Missing Teeth
- ☐ Receding Gums
- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Crooked/Crowded Teeth
- ☐ Denture Issue
- ☐ Jaw Click/Pain
- ☐ Grinding Teeth
- ☐ Sores in Mouth
- ☐ Teeth Gaps
- ☐ Crowns/Bridges
- ☐ Food in Teeth
- ☐ Other: _____

Confidential Medical Questionnaire

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist and/or hygienist will carefully review the questions before proceeding. Thank you for your time with this information.

Are you currently being treated for any medical condition or have you been treated within the past year? Please explain. ☐ Yes ☐ No

Has there been any change to your general health in the past year? If yes, please explain. ☐ Yes ☐ No

Are you currently taking any medication, non-prescription drugs, or recreational drugs? If yes, please list. ☐ Yes ☐ No

Do you have any allergies? If yes, Please list. ☐ Yes ☐ No

Are you pregnant or breastfeeding? What is the expected due date? ☐ Yes ☐ No

Have you ever had negative reactions to medication or injection? ☐ Yes ☐ No

Have you ever been hospitalized for any illnesses or operations? Please explain. ☐ Yes ☐ No

Are there any outstanding health issues such as operations, medication, conditions, or diseases, that have not been mentioned? Please list below. ☐ Yes ☐ No

Do you have or have ever had any of the following? Check all that apply.

☐ HIV or AIDS	☐ Diabetes Type 1/2	☐ Pacemaker
☐ Hepatitis A/B/C	☐ Asthma	☐ Cancer
☐ Heart Attack	☐ Seizures	☐ Kidney Disease
☐ Stroke	☐ Stomach Ulcers	☐ Thyroid Disease
☐ Shortness of Breath	☐ Bleeding Disorder	☐ Drug Addiction
☐ Chest Pain (angina)	☐ Arthritis	☐ Osteoporosis Meds
☐ Snore/CPAP Machine	☐ Artificial Joints	☐ Other: _____

By signing below, I agree that:

- **The medical and dental history information I have provided is complete and accurate**
- **I have reviewed, had the opportunity to ask any questions, and have agreed to the office privacy code, in the document "How our Office Collects, Uses and Discloses Patients' Personal Information"**
- **I have been informed of the cancellation policy and will provide 2 days notice to avoid a $50 cancellation fee**

Signature Date