Cedarwood DENTAL
Your Smile. Our Passion.

# Welcome

## Patient Information

□ Mr □ Mrs □ Ms □ Miss □ Dr First Name: _____ Last Name: _____
Preferred Name: _____ Date of Birth: _____ (DD/MM/YY) Gender: _____
Address: _____ Apt/Unit#: _____
City: _____ Province: _____ Postal Code: _____
E-mail address: _____
Work Number: _____ ext. _____
Cell Number: _____ Employer: _____
In case of an emergency – Please notify _____ Phone Number: _____

May we send you emails/texts about important office notifications, including appointment reminders? □ Yes □ No □
You have the option to withdraw your consent at any time.

Health Card: _____ Pharmacy: _____
Medical Alert: _____ BP: _____ INR#: _____

## Referral Information

**How did you hear about us?**

□ AMS Student Network
□ Building Sign
□ Flyer
□ Internet
□ Mobile Sign
□ Magazine
□ Newspaper
□ Social Media/Email
□ Television
□ Community Event: _____
□ Patient..... Name: _____
□ Radio..... Station(s): _____
□ Other..... Please specify: _____

## Insurance Information

Primary Insurance Company Information
Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
Policy Holder Contact Phone Number: _____ (if different from above)
Group Policy/Plan Number: _____ I.D./Certificate Number: _____
Marital Status: □ Single □ Married/Common Law □ Other
Insurance Company Name: _____

Secondary Insurance Company Information
Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
Policy Holder Contact Phone Number: _____ (if different from above)
Group Policy/Plan Number: _____ I.D./Certificate Number: _____
Insurance Company Name: _____

Responsible Party Name: _____ Signature: _____

*Dawson Dental Centres reserves the right to store outdated/inactive files offsite within the regulations of PHIPA guidelines. Further information would be available to you upon request. Please be aware there may be a nominal fee involved with retrieval of these documents. This would be at the discretion of the practice manager or prescribing doctor. I, the undersigned, agree to the above statements.*

**Patient Name (Please Print):** _____ **Signature:** _____ **Date:** _____
□ Patient □ Parent □ Guardian □ Patient □ Parent □ Guardian

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# Medical History

**Please check any of the following that apply to you:**

- □ *Heart condition*
- □ *Angina*
- □ *Heart surgery/procedures*
- □ *Heart attack*
- □ *Stroke/T.I.A*
- □ *Heart murmur*
- □ *Mitral valve prolapse*
- □ *Congenital heart disease*
- □ *Infective Endocarditis*
- □ *Pacemaker*
- □ *High blood pressure*
- □ *Low blood pressure*
- □ *General Anesthetic complications*
- □ *Diabetes: Type I or II*
- □ *Hypolglycemia*
- □ *HIV positive/AIDS*
- □ *Anemia*
- □ *Blood disorders*
- □ *Hepatitis A/B/C*
- □ *Hemophilia*
- □ *Excessive bleeding/bruising*
- □ *Immunedeficiencies*
- □ *Eating disorder*
- □ *Lupus*
- □ *Thyroid disease*
- □ *Kidney disease*
- □ *Liver disease*
- □ *Joint replacement*
  - *joint* _____
  - *date* _____
- □ *Cancer - type:* _____
  - *Date:* _____
  - *Radiation:* _____
  - *Chemotherapy:* _____
  - *Surgery:* _____
- □ *Asthma*
- □ *Respiratory conditions*
- □ *Tuberculosis*
- □ *Snoring/sleep apnea*
- □ *Dizziness/fainting*
- □ *HPV*
- □ *Herpes/cold sores*
- □ *Ulcers/acid reflux*
- □ *Intestinal/stomach problems*
- □ *Above average weight gain/loss*
- □ *Vision Impairment*
- □ *Hearing impairment*
- □ *TMJ (jaw joint) concerns*
- □ *Physical impairment*
- □ *Arthritis*
- □ *Osteoporosis*
- □ *Long-term Actonel/Fosomax use*
- □ *Epilepsy/seizures*
- □ *Cognitive impairment*
- □ *Depression*
- □ *Anxiety*
- □ *Mental health issues*
- □ *Drug/alcohol dependency*
- □ *Tobacco Use*
- □ *Other* _____

Do you have any allergies or sensitivities to Medications: _____

Food: _____

Environment: _____

Has your physician ever told you to take antibiotics prior to dental procedures? □ Yes □ No

Have you ever experienced complications following a medical or dental procedure? □ Yes □ No

Are you pregnant? □ Yes □ No If yes, how many weeks? _____ weeks

Is there anything else you think we should know regarding your medical history? □ Yes □ No

If yes, please describe _____

Are you taking any medications? □ Yes □ No

If yes, please specify _____

Family Physician's Name: _____ Physician's Phone Number: _____

***Information for our Patients***

*At Dawson Dental Centres, all professional dental services are performed by licensed members of the Royal College of Dental Surgeons ("Dental Professionals"), and all institutional health care services are performed independently by Dawson Dental Centres Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Dawson Dental Centres and Dawson Dental Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Dawson Dental Health Services.*

***Privacy Act and Consent to Treatment***

*By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Dawson Dental Centres and Dawson Dental Health Services; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Dawson Dental Centres to provide the services you are requesting.*

***Acknowledgment regarding Information Provided***

*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 regarding my medical – dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Dawson Dental Centres and Dawson Dental Health Services , my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Dawson Dental Centres and Dawson Dental Health Services in accordance with their current practices, which may involve transfer and retention offsite. I, the undersigned, acknowledge that the Dawson Dental Centres and Dawson Dental Health Services are relying upon the information which I have provided being accurate and complete.*

Patient (Please Print): _____ Signature: _____ Date: _____

□ Patient □ Parent □ Guardian □ Patient □ Parent □ Guardian

Dentist (Please Print): _____ Signature: _____ Date: _____

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# Dental History

Date of most recent dental visit other than a cleaning _____

I routinely see my dentist every: 3mos 6mos 12mos Not routinely

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your visit today? _____

On a scale of 1 to 10, with 10 being the highest rating...

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| How important is your dental health to you? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Where would you rate your current dental health? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| How fearful of dental treatment are you? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## Personal History

| | Yes | No |
|---|---|---|
| Have you ever had an unfavourable dental experience? | ☐ | ☐ |
| Have you ever had complications from past dental treatment? | ☐ | ☐ |
| Did you ever have braces, orthodontic treatment or had your bite adjusted? | ☐ | ☐ |
| Have you had any teeth removed? | ☐ | ☐ |

## Smile Characteristics

| | Yes | No |
|---|---|---|
| Is there anything about the appearance of your teeth that you would like to change? | ☐ | ☐ |
| Have you ever whitened your teeth? | ☐ | ☐ |
| Are you self conscious about your teeth? | ☐ | ☐ |
| Have you ever been disappointed with the appearance of previous dental work? | ☐ | ☐ |

## Bite and Jaw Joint

| | Yes | No |
|---|---|---|
| Do you have any problems chewing gum? | ☐ | ☐ |
| Do you have any problems chewing bagels or other hard foods? | ☐ | ☐ |
| Have your teeth changed in the last 5 years, become shorter, thinner or worn? | ☐ | ☐ |
| Are your teeth crowding or developing spaces? | ☐ | ☐ |
| Do you have to clench to make your teeth fit together? | ☐ | ☐ |
| Do you wake up feeling like you have been clenching or grinding your teeth? | ☐ | ☐ |
| Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? | ☐ | ☐ |
| Do you have tension headaches or sore teeth? | ☐ | ☐ |
| Do you wear or have you ever worn a bite appliance? | ☐ | ☐ |

## Tooth Structure

| | Yes | No |
|---|---|---|
| Have you had any cavities within the past 3 years? | ☐ | ☐ |
| Do you have a dry mouth? | ☐ | ☐ |
| Are any teeth sensitive to hot, cold, biting or sweets? | ☐ | ☐ |
| Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? | ☐ | ☐ |
| Do you avoid brushing any part of your mouth? | ☐ | ☐ |

## Gum and Bone

| | Yes | No |
|---|---|---|
| Have you ever been diagnosed or treated for periodontal (gum) disease? | ☐ | ☐ |
| Have you ever experienced gum recession? | ☐ | ☐ |
| Is there anyone with a history of periodontal disease in your family? | ☐ | ☐ |
| Do your gums bleed when brushing, flossing, eating? | ☐ | ☐ |
| Are your teeth becoming loose? | ☐ | ☐ |
| Have you ever noticed an unpleasant taste or odour in your mouth? | ☐ | ☐ |
| Have you experienced a burning sensation in your mouth? | ☐ | ☐ |