ST. JOHN'S Family Dentistry

Address: 7 William Graham Dr. Unit A1 Aurora, Ontario L4G 0V7
Phone: (905) 727-1717 | Fax: (905) 727-7070 | Email: info@stjohnsdental.ca

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION ON BOTH SIDES.

PERSONAL INFORMATION

Date _____
Day Month Year

Name _____

Address _____ Date of Birth _____ Age ____

City _____ Home Phone _____

Postal Code _____ Office Phone _____ Ext. ____

Occupation _____ Title: Mr. / Miss / Mrs. / Ms.

Name of Employer _____ Medical Doctor _____

Email _____

Name of person responsible for this account _____

Do you have dental insurance? _____

Company Name _____

Policy No. _____ % Covered _____

I.D. or S.I.N. No. _____

How did you hear about our practice? _____

MEDICAL HISTORY

	Yes	No
1. Have you ever had a serious illness, operation, or been hospitalized?	☐	☐
If Yes, explain _____		
2. Are you under the care of a physician now for any problem?	☐	☐
If Yes, explain _____		
3. Have you had a medical examination within the last year?	☐	☐
If Yes, explain _____		
4. Have you taken any medicines, drugs or pills presently?	☐	☐
If Yes, explain _____		
5. Have you ever taken or been given bisphosphonate medication or any of its family?	☐	☐

6. Do you have or have you ever had any of the following? (Circle)

Rheumatic Fever	Liver Disease (Jaundice, Hepatitis)	Thyroid Disease
Heart Trouble	Kidney Disease	Lung Disease
High Blood Pressure	Diabetes	Asthma
Heart Murmur	Epilepsy	Blood Disorders
Venereal Disease	Radiation or X-ray Disease	Anemia
Mental or Nervous Disease	Gastrointestinal Disease	Cancer
Joint Replacement	AIDS	Sinusitis

Other _____

7. Do you have any allergies?	☐	☐
If Yes, explain _____		
8. Are you allergic to any medicines or drugs?	☐	☐
If Yes, explain _____		

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	Yes	No
9. Have you ever had freezing (local anaesthetic) in your mouth?	☐	☐
Any ill effects from it? _____	☐	☐
10. Do you bleed abnormally?	☐	☐
11. Do you bruise easily?	☐	☐
12. Have you ever fainted? When? _____	☐	☐
13. Do you have shortness of breath?	☐	☐
14. Do you have any chest pains?	☐	☐
15. Do your ankles ever swell?	☐	☐
16. Have you gained or lost excessive weight recently?	☐	☐
17. Have you ever taken cortisone or steroids?	☐	☐
18. Is there any history of family disease?	☐	☐
19. Is there anything that the dentist should know regarding your medical history that has not been mentioned?	☐	☐
Explain _____		
20. To the best of your knowledge, are you in good health?	☐	☐
WOMEN: Are you pregnant?	☐	☐
If yes, in what stage of pregnancy? _____		

DENTAL HISTORY

1. Have you ever had a complete dental examination with a full series of dental x-rays within the past 3 years? ☐ ☐

2. Last dental visit? _____ What was done? _____

3. Have you had any extractions? ☐ ☐
   If yes, did you experience prolonged bleeding after? ☐ ☐

4. Have you ever had any of the following dental treatments? (Circle)

Root Canal	Orthodontics	Full or partial denture
Periodontal (gums)	Crowns or Caps	Bridgework

5. Are you aware of bad breath or a bad taste in your mouth? ☐ ☐

6. Have you ever had a bad experience at the dentist? ☐ ☐

7. What is your present dental problem? _____

Dentist Signature _____ Date _____

PATIENT/GUARDIAN APPROVAL AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

I also consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume the responsibility for fees associated with these procedures.

Signature _____ Date _____