GET ACQUAINTED QUESTIONNAIRE

Today's Date _____ DAY _____ MONTH _____ YEAR

PERSONAL INFORMATION

Name _____ Date of Birth _____ DAY _____ MONTH _____ YEAR

Home Address _____

City _____ Province _____ Postal Code _____

Telephone: Home _____ Business _____ Height _____ Weight _____

Employed by _____ How long _____ Occupation _____

Marital Status _____ Name of Spouse _____

Personal Physician _____ Telephone _____

Whom may we thank for referring you? _____ Previous Dentist _____

In case of emergency notify: Name _____ Relationship _____

Address _____ Telephone _____

Do you have dental insurance? _____ Group Policy # _____ Div. # _____

Employee # _____ % Covered _____

Do you have a second dental plan or any other type of coverage? _____

SIN # _____ AHC # _____

Maiden Name: _____ E-mail _____

Name of person responsible for account _____

MEDICAL HISTORY

		CIRCLE	
1.	Have you ever been hospitalized and was surgery performed?	YES	NO
	Please specify _____		
2.	Is your physician treating you now?	YES	NO
	Please specify _____		
3.	Do you have heart disease or a heart murmur?	YES	NO
4.	Are your ankles often swollen?	YES	NO
5.	Have you had rheumatic fever?	YES	NO
6.	Have you ever had liver or kidney trouble?	YES	NO
7.	Have you ever had venereal disease?	YES	NO
8.	Are your activities limited?	YES	NO
9.	Do you become breathless easily?	YES	NO
10.	Have you had abnormal bleeding?	YES	NO
11.	Have you ever gained or lost excessive weight recently?	YES	NO
12.	Have you ever had radiation or X-ray therapy?	YES	NO
13.	Have you taken cortisone or steroids?	YES	NO
14.	Have you any allergies?	YES	NO
15.	Have you had an allergic reaction to any drugs or medicines ie. Penicillin?	YES	NO
	Please specify _____		
16.	Are you taking any prescription or non-prescription drugs or medicines?	YES	NO
	Please specify _____		
17.	To the best of you knowledge, have you ever come in contact with AIDS?	YES	NO
18.	Do you have or have you had? *Please circle*		

Heart trouble or chest pain	Tuberculosis	Malignant Hypothermia	Diabetes
High blood pressure	Asthma	Anaemia	Cancer
Venereal disease (syphilis, gonorrhea)	AIDS / HIV	Epilepsy	Herpes
Thyroid trouble	Blood disorders	Any others - Specify _____	

19.	Do you smoke or use tobacco products? (If yes, how much?) _____	YES	NO
20.	Are you immunocompromised or deficient?	YES	NO
21.	Are you on a special diet?	YES	NO

continued on other side ☞

22. Are you currently in good health? ..... YES NO
23. Is there anything else you think you should tell me? ..... YES NO
    Please specify _____
24. FOR WOMEN ONLY
    Are you pregnant? If yes, what month? _____ ..... YES NO

DENTAL HISTORY

1. Have you ever been under regular care by a dentist? ..... YES NO
2. When was your last visit? _____ YES NO
3. Have you ever had local anaesthetic (freezing), general anaesthetic, nitrous oxide? *(please circle)* ..... YES NO
4. Were there any complications? ..... YES NO
   Please specify _____
5. Have you ever had any teeth extracted? ..... YES NO
6. Were there any complications involved afterwards? ..... YES NO
   Please specify _____
7. Do any of your teeth ache? ..... YES NO
8. Do your gums bleed when you brush? ..... YES NO
9. Do your gums feel tender or swollen? ..... YES NO
10. Do you have any loose teeth? ..... YES NO
11. Describe in your own words, your present dental problem _____
    _____
12. Are you happy with the appearance of your teeth? _____ YES NO
    _____
    _____
    _____

OFFICE POLICY

Our office policy is that services are paid for at each visit as they are performed.

Your appointment time is reserved especially for you. A fee may be charged to you for last minute cancellation or failing to show for your appointment.

ALL SERVICE CHARGES AND NSF CHEQUES INCURRED WITH RESPECT TO YOUR ACCOUNT ARE YOUR FULL RESPONSIBILITY

Patient's (Parent's) Signature _____ Date _____

TREATMENT CONSENT

This is to certify that I, undersigned, consent to the performing of the dental or oral surgery procedures agreed to be necessary or advisable, including the use of general or local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature _____ Date _____

QUESTIONNAIRE UPDATE

Please check over and update information, with a different coloured pen, to ensure that all information is correct and sign below.

1. Date _____ Signature _____
2. Date _____ Signature _____
3. Date _____ Signature _____
4. Date _____ Signature _____
5. Date _____ Signature _____
6. Date _____ Signature _____