Beaufort Family Dental

WELCOME TO OUR DENTAL OFFICE! **Dr Bill Toews, Dr Greg Gill & Dr Hilary Linton**

Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain in this office. Please do not hesitate to ask for assistance if required.

Patient: ______________________ ______________________ ______________________
First **Last** **Preferred Name** (if applicable)

If patient is a child, name of parent(s)/guardian: ______________________

Mailing Address: ______________________
____
Emergency Contact: ______________________
Preferred Method of Contact: ______________________

Date of Birth: ______________________
Cell Phone #: ______________________
Home Phone #: ______________________
Email: : ______________________

How did you hear about our office? ______________________

DENTAL INSURANCE (if applicable)

Primary Coverage

Insurance Company ______________________
Name of policy holder ______________________
Employer ______________________
Group Policy # ______________________
Member ID # ______________________

Secondary Coverage

Insurance Company ______________________
Name of policy holder ______________________
Employer ______________________
Group Policy # ______________________
Member ID #______________________

CONFIDENTIAL MEDICAL HISTORY

Physician's name______________________ Phone #:______________________

1. When was the last time you had a medical examination? ______________________
2. Please indicate below (X) if you **presently have** or **have ever had any** of the following:

- ☐ Heart Conditions (ie. high blood pressure, chest pain, stents, valves, pacemaker)
- ☐ Strokes
- ☐ Seizures/Fainting/Dizzy spells
- ☐ Hip/Knee/Orthopaedic conditions
- ☐ Cancer (chemotherapy, radiation)
- ☐ Diabetes (high blood sugar, Type I or II)
- ☐ Previous Surgeries
- ☐ Kidney problems
- ☐ Stomach problems (ie. ulcers, heartburn)
- ☐ Liver problems
- ☐ Bleed or bruise easily
- ☐ Breathing problems (ie. asthma, COPD)
- ☐ Eating Disorders (anorexia, bulimia)
- ☐ Mood Disorders (depression, anxiety, etc.)
- ☐ Communicable Disease (Hepatitis A,B,C, HIV, Tuberculosis)
- ☐ Other: ______________________

Please provide any further details or medical conditions: ______________________
____
____

3. Have you been hospitalized in the last 5 years? Yes No If yes, please provide details: ______________________
____

4. Please note any prescription medication, recreational substances, or supplements: ***We can scan a list if you have one***

Name ____________________________ Reason ____________________________

Name ____________________________ Reason ____________________________

Name ____________________________ Reason ____________________________

Name ____________________________ Reason ____________________________

Name ____________________________ Reason ____________________________

5. Have you ever been advised to take antibiotics prior to dental treatment? Yes No Hip / Knee / Heart Valve or Defect

6. Do you have any allergies (food, medication, latex)? ____________________________

7. Have you ever had a reaction to dental local anesthetic? Yes No

8. Do you smoke or use tobacco? Yes No Previously, but quit If yes, how much?____________________

9. Do you exercise? Yes No If yes, how frequently?____________________

10. Female patients: Are you pregnant or think you may be pregnant? Yes No Breastfeeding? Yes No

DENTAL HISTORY

What brings you in today? ____________________________

____

Date of last dental visit: ____________________ What was done at your last dental visit?____________________

Previous Dentist for Records? ____________________________

Do you have regular dental hygiene appointments? Yes No If yes, how often? ____________________

What toothbrush do you use? Philips Sonicare Oral B Power Manual: reg / soft ____________________

How frequently do you floss? ____________________________

Do you experience tooth sensitivity to hot or cold temperatures? ____________________________

Do you grind or clench your teeth? Yes No Do you have a nightguard? Yes No

Do you suffer from: Headaches? Yes No Earaches? Yes No Neck aches? Yes No

Do you experience dry mouth? Yes No

Is there anything else we should know in order to keep your dental experience safe and comfortable?

____

____

AUTHORIZATION

I hereby certify that the information provided above is correct and is for the benefit of my treatment. If I have a change in my health, I will inform the office at my next dental appointment. I consent to the release of medical information from my medical doctor or other health care provider as required by the Dentist. I authorize the diagnosis of my dental health by means of radiographs (including x-rays), photographs or other diagnostic aids deemed appropriate. I understand that it is my responsibility to pay for all fees incurred for myself and any dependents, including any fees not covered by a dental plan (if applicable).

*Please note our C**ancellation Policy**: To avoid a fee, our clinic requires a minimum of **24 HOURS NOTICE** in order to makes changes to your scheduled appointment.*

x____________________________ ____________________________

Signature of Patient or Parent/Guardian Today's Date