West Ajax Dental
info@westajaxdental.ca

PATIENT INFORMATION

Welcome to Our Dental Office!

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. Please fill in the entire form.

PERSONAL INFORMATION

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms

First Name: _____ Last Name: _____

Mid: _____ Preferred Name: _____

Status: ☐ Single ☐ Married ☐ Child ☐ Other

Date of Birth (DD/MM/YY): _____/_____/_____

Home Address: _____ Apt: _____

City: _____ Postal Code: _____

Email: _____ Home Tel: _____

Work Tel: _____ Cell: _____

Employer: _____ Occupation: _____

Physician: _____ Physicians Phone No: _____

Previous Dentist: _____

Why have you decided to change dental offices? _____

How did you hear about us? _____

INSURANCE INFORMATION 1

Name of insured if different from above: _____

Employer: _____ Date of Birth of Insured (DD/MM/YY): _____/_____/_____

Insurance Company: _____ Policy/Group: _____

Division (If applicable): _____ Certificate ID#: _____

Do you have Secondary Insurance? ☐ No ☐ Yes **(Please fill out the next section)**

INSURANCE INFORMATION 2

Name of insured if different from above: _____

Employer: _____ Date of Birth of Insured (DD/MM/YY):_____/_____/_____

Insurance Company: _____ Policy/Group: _____

Division (If applicable): _____ Certificate ID#: _____

EMERGENCY CONTACT

Relationship: _____ Name: _____

Tel: _____

MEDICAL HISTORY

	YES	NO
Are you being treated for any medical condition at the present or have you been treated within the last year?	☐	☐
If yes, specify: _____		
When was your last medical check-up? _____		
Has there been any change in your general health in the past year?	☐	☐
Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:	☐	☐

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____

	YES	NO
Do you have any allergies ☐Latex ☐Other: _____	☐	☐
Have you had an unusual reaction to any drugs or medicines?	☐	☐
☐ Penicillin ☐ Sulfonamide ☐ Aspirin ☐ Codeine ☐ Local Anesthetic ☐ Other: _____		
Have you taken Oral/ IV Bisphosphonates medications? or are you still taking them?	☐	☐
Do you have a bleeding problem or bruise easily? Are you on blood thinner?	☐	☐
Do you have any conditions that could affect your immune system ego AIDS, HIV infection, Leukemia etc?	☐	☐
Do you smoke? If yes, how much? _____	☐	☐
Have you ever been hospitalized for any serious illnesses or operations?	☐	☐

Do you have or have you ever had any of the following?

☐ Chest Pain/Angina	☐ Heart Attack	☐ High Blood Pressure	☐ Emphysema	☐ Asthma
☐ Epilepsy	☐ Thyroid Disease	☐ Kidney Disease	☐ Cancer	☐ Chemotherapy/Radiation
☐ Psychiatric Disorder	☐ Tuberculosis	☐ Arthritis	☐ Steriods	☐ Cortisone
☐ Stomach Ulcers	☐ Diabetes	☐ Drug/Alcohol Dependency	☐ Stroke	☐ Sinus Problems
☐ Organ Transplant	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Pacemaker	☐ Jaundice
☐ Hepatitis	☐ Liver Disease	☐ Prosthetic Joints	☐ Artificial Joints	☐ Rheumatic Fever

For females: Are you pregnant or breast feeding?	☐	☐
Any other conditions or problems of which the dentist should be aware of?	☐	☐

If yes, please list: _____

	YES	NO
Have you ever experienced any of the following jaw problems?		
- Popping/clicking in your jaw joints?	☐	☐
- Pain in your jaw joints, around your ear, orside of your face?	☐	☐
- A bite plate or any other appliance?	☐	☐
- Difficulty in opening or closing?	☐	☐
- Pain or difficulty while chewing?	☐	☐
Do you have any of the following habits?		
- Clenching or grinding your teeth while awake or asleep?	☐	☐
- Biting your cheeks or lips?	☐	☐
- Mouth breathing while awake or asleep?	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)?	☐	☐
Have you ever had any of the following?		
- Periodontal Treatment? (treatment of the gums)	☐	☐
- Orthodontic Treatment? (to straighten or realign teeth)	☐	☐
- A bite plate or any other appliance?	☐	☐
- Your bite plate or any other appliance?	☐	☐
- Oral surgery? (surgery in or about the mouthjaw joint surgery in one or both of your jaw joints?)	☐	☐

If you answered "yes" to the last question, who performed the surgery? _____When?_____

When was your last dental visit? _____

When did you last have dental x-rays? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Have you been seeing a dentist regularly?	☐	☐
Do any of your teeth ache?	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐
Do your gums bleed when you brush?	☐	☐
Do you have any pain when you chew?	☐	☐
Do you feel that you have bad breath?	☐	☐

	YES	NO
Have you ever been in a motor vehicle accident or experienced any blows to your jaw?	☐	☐
Have you ever had a dental implant surgery?	☐	☐
If yes, who performed the surgery and when was it done? _____		
Are you being followed-up by a dental specialist?	☐	☐
Please list anything else not mentioned above regarding your past dental history: _____		

I UNDERSTAND that in order to get my examination:

1. You will be asked about medical history, dental history, current and previous, Chief complaint, goals of the treatments. You will disclose the current accurate information to the best of your knowledge.
2. All information you share is confidential, only necessary information is collected about you.
3. I only share your information with your consent.
4. Storage, retention and destruction of your personal information complies with existing legislation, and privacy.
5. Privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons.
6. Extra oral exam, Intra oral exam, elective Oral cancer screening, TMJ assessment, Dental Occlusion Assessment, Specific Exam, or Second opinion are all procedures that need the use of sterilized dental instruments that will be used during the exam. You have the right to deny use of any instruments. You have the right to ask all the questions about different procedures and getting them explained to you before they are conducted.
7. Collecting additional information such as, dental casts or impressions, x-ray or other means of imaging, photography, Referral to other specialists such as and not limited to: Periodontists, Endodontists, Orthodontists, Oral medicine, Oral anaesthesia, Maxillofacial Surgeon and Physician is needed to formulate accurate diagnoses and you will be informed about them as needed. You have the right to deny any of those data collections procedures.
8. You authorize photos, slides, and x-rays of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Please email info@westajaxdental.ca when completed

Signature of Patient_____ Date_____

Signature of Dental Specialist_____ Date_____