Chelmsford Dental Clinic
44-C Main Street East, Chelmsford, Ontario. P0M 1L0.

Patient Name: Last Name First Name Middle Name

Preferred Name

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's Name:

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contact or glasses)?

☐ Are you currently taking any prescription or non-prescription medications?

List All Medications, Herbal Supplements and Over the Counter Medications Taken:

WOMEN ONLY : Are you pregnant?

◯ Yes ◯ No

If yes, when is the due date?

Date

Please indicate if you have experienced any of the following:

Med list Doc Center	***Pre-Medication**	***See Patient Notes**
Allergy - * See Notes	Allergy - Aspirin	Allergy - Codeine
Allergy - Iodine	Allergy - Latex	Allergy - Penicillin
Allergy - Sulfa	Allergy - Erythromycin	Allergy - Local Anesth
Anemia	Arterial Stents	Arthritis
Artificial Joints	Asthma	Blood Thinners
Bronchitis	Cancer	Celiac Disease
Contraceptive Use	Deep Vein Thrombosis	Depression
Diabetes	Dizziness/Fainting	Emphysema
Epilepsy	Excessive Bleeding	Exclusive Brushing
Fibromyalgia	Gastro - Intestinal	Glaucoma
Hay Fever	HBP	Head Injury
Hearing Disabled	Heart Disease	Heart Murmur
Hepatitis A	Hepatitis B	Hepatitis C
HIV+ (AIDS)	Kidney Disease	LBP
Liver Disease	Mental Disorders	Multiple Sclerosis
Nervous Disorders	Osteoporosis with RX	Pacemaker
Pregnancy	Radiation Treatment	Respiratory Problems
Rheumatism	Rheumatoid Arthritis	Sinus Problem
STD	Stomach Problem	Stroke
Thyroid Disease	Tuberculosis	Tumors
Wheelchair		

Do you have any other health issue or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address & Phone number:

How frequently do your brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2-6 weekly ◯ 1-6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform to the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect, and/or inaccurate information has being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or health care practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my dependents (if any)

Signature of patient, parent, or guardian:

Signature: Date

(18 years and under)

Relationship to patient:

Response Date