234 Laurier Avenue West, Ottawa On, K1P 6K6

613-233-1118

Health information and History

Today's Date: ______________

Patient's Name: ______________

Birth Date: ______________

Full Address: ______________

Phone Numbers: ______________ **Work:** ______________

Email Address: ______________

*****If you are completing this health questionnaire for another person**

Name: ______________
Phone Number: ______________
Relationship: ______________

Emergency Contact:

Name: ______________
Phone Number: ______________
Relationship: ______________

Primary Physician:

Name: ______________
Phone Number: ______________
Date of Last Physical Examination: ______________
Other physician or Specialist: ______________
Last Dental Examination ______________
Last Dental Hygiene appointment ______________
Last Dental X-rays ______________

1-In the past 3 Years have you ever been:

Hospitalized: **Yes or No** If yes, for what reason(s):

____

Had Surgery: **Yes or No** If yes, for what reason(s):

____

2-Are you allergic to or have experienced a reaction to:

( ) Latex
( ) Metals or jewelry
( ) Dental Anesthesia
( ) General Anesthesia
( ) Fluoride
( ) Nitrous Oxide (Laughing Gas)

3-Are you allergic or have experienced a reaction to any of the following drugs?
(Please check if you are allergic)

( ) Penicillin (or related drugs)
( ) Tetra Cycline
( ) Aspirin/ Ibuprofen (Advil,Motrin)
( ) Sulfa Drugs
( ) NSAID (Celebrex, Vioxx, Anaprox)
( ) Erythromycin
( ) Tranquilizers (Valium)
( ) Codeine
( ) Keflex (Cephalexin)
( ) Iodine
( ) Clindamycin

4- Do you have any food allergies? **Yes or No**
If yes Please specify what and the type of reaction that can occur:

____
____

5- Do you have any other allergies such as bees? **Yes or No**
If yes Please specify what and the type of reaction that can occur:

____
____

--Do you or must you carry an Epi-Pen? **Yes or No**

--Do you or must you carry asthma pumps? **Yes or No**

6- Have you had an allergic reaction or unusual response to ANY other medication, drug, pill, or treatment? **Yes or No**
If YES, Please List: ______________

7- Do you have, or have ever had, any of the following? (Please check YES or NO for each question)

		Yes	No
Congenital heart defects	______	( )	( )
Congestive heart failure	______	( )	( )
Coronary artery disease	______	( )	( )
Heart surgery	______	( )	( )
If yes, when ______________			
Heart Attack	______	( )	( )
If yes, when ______________			
Infective endocarditis	______	( )	( )
Heart valve(s) damage/Mitral valve prolapse	______	( )	( )
Artificial heart valve	______	( )	( )
Angina or chest pains	______	( )	( )
Pacemaker	______	( )	( )
Anemia	______	( )	( )
Stroke or CVA	______	( )	( )
High blood pressure	______	( )	( )
Low blood pressure	______	( )	( )
Hemophilia or bleeding disorder	______	( )	( )
Excessive bleeding from any cut or incident	______	( )	( )

A sore or wound that bleeds easily or does not heal ________( ) ( )
Atherosclerosis ________( ) ( )
A thyroid problem or disease ________( ) ( )
Any kidney problems ________( ) ( )
Ulcers, acid reflux, or stomach problems ______ ( ) ( )
Diabetes or blood sugar problems ________( ) ( )
Cholesterol problems ________( ) ( )
Rheumatic fever ________( ) ( )
Asthma ________( ) ( )
Sinus problems ________( ) ( )
Tuberculosis, emphysema or lung disorder ________( ) ( )
Hay fever, skin or food allergies ________( ) ( )
Skin prone diseases ________( ) ( )

If yes, when ____

Arthritis ( ) ( )
Glaucoma or any eye disease ( ) ( )
Any artificial joint, joint surgery or prosthetics ( ) ( )

If yes, please list:____

An organ transplant ( ) ( )
A compromised Immune system ( ) ( )
(Lupus, HIV, AIDS, radiation immune problems, etc) ( ) ( )
Active sexually transmitted disease (STD) ( ) ( )
Epilepsy or other seizure disorder ( ) ( )
Been treated for psychiatric condition ( ) ( )
Any Mental Health Issues ( ) ( )
Cancer ( ) ( )

If yes what kind:____

Women Only

-Are you Pregnant ____

-If yes, what is your due date________________________________ ________

-Do you think you might be pregnant ___________________________________

-Are you presently nursing ____

- Are you using birth control ____

-Are you taking any hormone replacement therapy __________________________

8- Are you taking any drugs, medications, supplements or treatments at this time?

Yes or No

If yes, please indicate what kind(s) and for what reason(s)

____
____
____

9- Do you have any other conditions, disease or medical problems or inflammation that you would like us to know about or should know about?

YES or NO

If Yes, Please explain:____

Dental and Oral Health Information

10-Are you satisfied with your smile? **Yes or No**

If No please Explain:____

____
____

If you could change anything what would it be: ____________________________

____
____

11- Do you have any missing teeth?

Yes or No

If yes please specify____

12-Do you wear any removable appliances?(partials or dentures)

Yes or No

If yes please specify____

13-Have you ever had your teeth whitened or bleached? **Yes or No**

If yes please indicate the type:_______________________________________

Would you like to have your teeth Whitened or Bleached? **Yes or No**

14-Have you had any of the following Treatments:

Periodontal **Yes or No Date:**____________________
Orthodontics (Braces) **Yes or No Date:**____________________
Crowns (Cap) **Yes or No Date:**____________________
Bridge **Yes or No Date:**____________________
Root Canal **Yes or No Date:**____________________
Extractions (Including Wisdom Teeth) **Yes or No Date:**____________________

15-Do you have/had or noticed any of the following signs or symptoms?

Teeth sensitive to hot, cold, sweets or biting pressure **Yes or No**
Unpleasant Taste or constant bad breath **Yes or No**
Food trapped between your teeth **Yes or No**
Do your gums bleed ________**Yes or No**
Receding gum line ________**Yes or No**
Avoid any area when brushing or chewing ________**Yes or No**
Clench or grind your teeth **Yes or No**
Clicking, snapping or difficulty when chewing ________**Yes or No**
Trouble opening or moving your jaw ________**Yes or No**
Trouble moving your tongue ________**Yes or No**
Loose or separating teeth ________**Yes or No**
Color change of your teeth or gums ________**Yes or No**
Pain, tenderness, numbness, or earaches ________**Yes or No**

Any lumps, swelling or swollen glands ________**Yes or No**
Sores, ulcers, or rough spots in your mouth ________**Yes or No**

16- Have you ever had any complications from an extraction or dental treatment?

Yes or No

If yes, Please explain____

17 - Have you ever had any major trauma or injury to you head, neck or mouth? **Yes or No**

If yes Please explain____

18-How do you rate your overall dental heath? Fair Good Poor

19-How many times a day do you brush your teeth? ____________________________________

20-How many times a week do you floss?______________________________________

21- Do you use the following?

Electric Toothbrush **Yes or No**

Flossing Aid(Floss holder, threaders) **Yes or No**
Oral Irrigating device (Waterpik) **Yes or No**
Fluoride treatments or supplements? **Yes or No**
If yes what kind/which one_______________________________________

Mouthwashes or oral rinses **Yes or No**
If yes what kind or brand_______________________________________

22- If you could change something about your smile what would it be?

____

Oral Health Risk Factors

23-Do you smoke or have you ever smoked? Yes or No
What kind, how much and for how long?____
____

24-Do you or have you ever chewed tobacco or anything else similar? Yes or No

If yes What kind, how much and for long:____

25-Do you consume alcoholic beverages? Yes or No
How much in a week or in a month? ____

26-Do you presently use recreational drugs? Yes or No
If yes please list:____

27- Do you or have you ever had any head/mouth or neck piercings? Yes or No

What and how much? ____

CONSENT— To the best of my knowledge, all the preceding information is correct and if there is ever any changes in my health, or medications, this practice will be informed of all changes without fail. I also Consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care for future treatments. I also hereby consent to allow diagnosis, proper heath care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature: _____ ______________ _______________

Date:____

Reviewed by:____

Special Instructions (for Dentist)

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Payment policy for major dental treatments, requiring two or more visits.

Major treatments includes, crowns, inlays or onlays, crowns on implant, bridges, partial denture, complete dentures and some surgeries such as bone grafting, sinus lift and implant placement.

These major treatments require a few visits and can be costly. Since we understand that everyone is on a budget we always provide an estimate beforehand and explain how we can proceed with the payments.

-For crowns, inlays or onlays, and Bridges it is normal to see you twice. Once for the preparation and the second time for the final insertion. Therefore we divide the payments in half.

-For Partial Dentures and Complete dentures we see each other approximately 3-4 times. Therefore we divide the payments in three.

-For the major Surgeries we start the payments before the initial appointment. We can start 2 months ahead of the actual appointment, as long as the last payment is made on the day of the surgery. We can set an agreement with our Secretaries or Office Manager.

Once these treatments are completely finished or installed we may send out the claim to your insurance company. Your insurance company may send a letter to you, asking questions regarding this treatment. It is your responsibility to bring this letter to our office for us to answer these questions on your behalf.

This form is to properly advise you on our payment policies concerning major treatments at Le Centre Dentaire De Dr. France Chevalier.

By signing this form I consent that I am completely informed about the payment policies and I accept.

____
(Date)

____ ______________________________________

(Patient signature) (Witness)