sappertondental
FAMILY & COSMETIC DENTISTRY

The staff at Sapperton Dental would like to welcome you to their practice.

To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire.

Personal Details

Name_____

Date of Birth_____Age_____Sex_____Marital Status_____

Address_____City_____Postal Code_____

Phone Home_____Work_____Cell_____

Email Address_____

Insurance Company_____ Policy#_____ ID#_____

Policy Holder's name: _____Date of Birth of Policy Holder: _____

What is your preference for communication from our practice?

Home ☐ Work ☐ Cell ☐ Email ☐

Who can we send a thank you for your referral?_____

In Case of Emergency please notify

Name:_____ Relationship:_____ Telephone #_____

Dental History

Are you having any discomfort at this time? If yes please specify:_____

Have you been under the regular care of a dentist and what was done recently?_____

How long ago was your last dental visit?_____

Do your gums feel tender or swollen? **Y/N** Is there often bleeding when you floss? **Y/N**

Have you ever been given local anaesthetic (freezing)? **Y/N** Have you ever had general anaesthetic (asleep)? **Y/N**

Are you aware of any lump or swelling in your mouth? **Y/N** Are you satisfied with the appearance of your teeth? **Y/N**

Are you tense during dental visits? **Y/N** Do you have an unpleasant taste or odour in your mouth? **Y/N**

Describe what you would like done with your teeth:_____

Do you currently experience any of the following?

Loose teeth **Y / N** Neck Pain/Headache/Ear aches **Y / N** Nosebleed Y **/ N** Unsatisfactory dentures **Y /N**

Popping or clicking in the jaw joints **Y / N** Gagging **Y / N** Missing or crooked teeth **Y / N**

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Medical Information

Medical Doctor: _____Do you consider yourself to be in good health? Y/N

Are you presently under the care of a medical doctor: If yes please specify:_____

Are you presently taking <u>any medication</u>, including non-prescription:_____

Do you have any allergies or have you had any reaction to (medications, anaesthetics, metals, latex,

antibiotics, pain killers:_____ Have you had heart surgery? Y/ N If yes when?:_____

Do you have to take antibiotics prior to dental work? If yes, why?_____

Do you have any artificial prosthesis (Joints, heart valve, etc)? If yes please specify:_____

Do you have abnormal bleeding?_____

Do you have or have you had any of the following:

High Blood Pressure	Y / N	Anemia	Y / N	Sinus Problem	Y / N	Low Blood Pressure	Y / N
Arthritis	Y / N	Cancer	Y / N	Tuberculosis	Y / N	Venereal Disease	Y / N
Psychiatric Care	Y / N	Herpes	Y / N	Headaches	Y / N	Nervous Problems	Y / N
Thyroid Problems	Y / N	Diabetes	Y / N	Stroke	Y / N	Heart Disease	Y / N
Head/Neck Injuries	Y / N	Hepatitis	Y / N	Chest Pain	Y / N	Blood Disorders	Y / N
Asthma	Y / N	Liver Disease	Y / N	Epilepsy	Y / N	Rheumatic Fever	Y / N
Heart Murmur	Y / N	Ulcer	Y / N	HIV/Aids	Y / N	Digestive Disorders	Y / N
Emphysema	Y / N	Glaucoma	Y / N	Chemotherapy	Y / N	Radiation Therapy	Y / N
Antidepressants	Y / N	Anxiety Disorder	Y / N	Heart Problems	Y / N	Alcohol/Drug Dependency	Y / N

Others:_____ Do you smoke/ how much?_____ Do you take recreational drugs?_____

Women: Are you taking Birth Control Pills? _____Are you pregnant?_____

Office Policy :Your appointment time will be reserved especially for you. If you are unable to keep the appointment we require two business days notice, otherwise, it may be necessary to charge for the time lost. _____Please initial

The dentist shall obtain my verbal consent before performing any dental procedure. I understand that I am ultimately responsible for the total fees associated with the treatment performed this is including the fees not covered by my insurance policy _____Please initial.

Patient or Guardian Signature:_____ Date:_____

Parent or Guardian Names:_____

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