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____

What is your preference for communication from our practice? (please circle)

Home Work Cell Email

Employed by___________________________________Occupation_________________________

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

In Case of Emergency please notify

Name:____Relationship:_______________________

Telephone: Home____________________Work____________________Cell______________________

Address:____

Dental History

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

____

Have you been under the regular care of a dentist?____

How long since your last dental visit?____

What was done at that time?____

Do your gums feel tender or swollen?____

Is there often bleeding when you floss?____

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FAMILY & COSMETIC DENTISTRY

Have you ever been given local anesthetic (freezing)?____
Have you ever had general anesthetic?____

Are you aware of any lump or swelling in your mouth?____

Are you satisfied with the appearance of your teeth?____

Are you anxious to keep your natural teeth?____

Are you tense during dental visits?____

Are you interested in a method to calm your nerves?____

Do you have an unpleasant taste or odor in your mouth?____

Describe what you would like done with your teeth:____

Do you currently experience any of the following:

Loose teeth	Y / N	Neck Pain	Y / N		
Bad breath	Y / N	Nosebleed	Y / N	Unsatisfactory dentures	Y / N
Ear ache	Y / N	Bleeding gums	Y / N	Popping or clicking in the jaw joints	Y / N
Gagging	Y / N	Headache	Y / N	Missing or crooked teeth	Y / N

Medical Information

Medical Doctor:____Telephone:____________________

Date of last physical exam: __________________Do you consider yourself to be in good health?__________

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

____

Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins:___

____

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

antibiotics, pain killers, dairy, etc.):____

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

Have you had heart surgery? If yes, please specify:____

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

Do you have abnormal bleeding?_______________Do you become breathless easily?____________________

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FAMILY & COSMETIC DENTISTRY

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?____________If so how much?_________________Do you take recreational drugs?________

Women: Are you taking Birth Control Pills?____________________Are you pregnant?___________________

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.
Signed:____

Office Policy

Your appointment time will be reserved especially for you. **If you are unable to keep the appointment we require 48 hours' notice, otherwise, it may be necessary to charge for the time lost.**
It is likely that there will be a difference in fees paid by my insurance company and charged by my dentist.

I understand that I am ultimately responsible for the total fees associated with the treatment performed. Including the fees not covered by my insurance.____________________(please initial)

Date:______________________Patient/Guardian Signature:_______________________________________

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