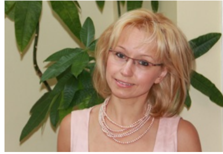
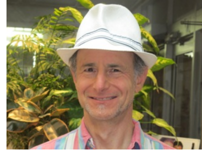
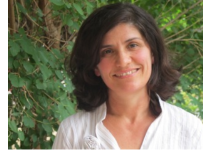
Vivian Duffy


Dr. Monika Kiepas


Dr. David Burman

Gina Arancon-Kovesdi


Luiza Kaci

Susan Ching-Ju Yang

PERSONAL INFORMATION

Title _______ Family Name _________________________ First Name __________________

Date of Birth (dd/mm/yy) _____________________________ Sex: M ☐ F ☐

Street # ____

City____ Postal code_______________

Home phone _____________________Business phone ______________________________

Who may we thank for referring you? ____

Person to contact in case of emergency:

Name____Phone __________________

PLEASE REFER TO MEDICAL QUESTIONNAIRE ON NEXT PAGE

MEDICAL HISTORY QUESTIONNAIRE

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. The dentist will review the questions and explain any that you do not understand. Please provide as much information as you can.

1. Are you being treated for any medical condition at present or have you been treated within the past year? ☐ Yes ☐ No ☐ Not Sure
Explain____

2. When was your last medical checkup?_________________________________

3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ No If yes, please list: ____

____

____

4.Do you have any allergies? If you answered yes, please list, using categories below:
☐ Yes ☐ No ☐ Not Sure

Medications ☐ ____
Latex/Rubber Products ☐ ____
Other (Hay-fever, foods) ☐ ____

5. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure

____

6. Do you have or have you ever had asthma?
☐ Yes ☐ No ☐ Not Sure

7. Do you have or have your ever had any heart or blood pressure problem?
☐ Yes ☐ No ☐ Not Sure

8. Do you have an artificial heart valve?
☐ Yes ☐ No ☐ Not Sure

9. Do you have a prosthetic or artificial joint?
☐ Yes ☐ No ☐ Not Sure

10. Have you ever been advised by your doctor to take antibiotics every time you have dental treatment? ☐ Yes ☐ No ☐ Not Sure

11. Do you have any conditions or therapies that could affect your immune system e.g. Leukaemia, AIDS, HIV, radiotherapy, chemotherapy?
☐ Yes ☐ No ☐ Not Sure

12. Have you ever had hepatitis, jaundice or liver disease?
☐ Yes ☐ No ☐ Not Sure

13. Do you have a bleeding problem or blood disorder?
☐ Yes ☐ No ☐ Not Sure

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure

____

15. Do you have or have you ever had any of the following? Please check:

☐ Chest Pain	☐ Angina	☐ Shortness of Breath
☐ Pace Maker	☐ Steroid Therapy	☐ Seizures (Epilepsy)
☐ Drug/Alcohol Dependancy	☐ Heart Attack	☐ Lung Disease
☐ Kidney Disease	☐ Tuberculosis	☐ Arthritis
☐ Stroke	☐ Prosthetic Heart Valve	☐ Stomach Ulcers
☐ Thyroid Disease	☐ Cancer	☐ Diabetes

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain: ☐ Yes ☐ No ☐ Not Sure

____

17. Have you ever smoked or chewed tobacco products?
☐ Yes ☐ No

18. Are you nervous during dental treatment?
☐ Yes ☐ No

19. For women only: Are you breast-feeding or pregnant? If pregnant, what is expected delivery date? ☐ Yes ☐ No ☐ Not Sure

____

Name of Family Doctor: ____

Phone #: ______________________________

I authorize my dentist to obtain medical information from my physician(s).

Patient/Guardian Signature: ________________________Date: ______________

Dentist Signature: ______________________________Date______________

PLEASE REFER TO DENTAL QUESTIONNAIRE ON NEXT PAGE

DENTAL QUESTIONNAIRE

1. Reason for this visit: ____

2. Are you experiencing pain in your teeth or gums? ☐ Yes ☐ No

   If YES, how would you describe the pain?

   ☐ mild ☐ constant ☐ moderate

   ☐ intermittent ☐ severe ☐ spontaneous

   Provoked by:

   ☐ cold ☐ hot ☐ chewing

3. Do you get headaches?

   ☐ often ☐ occasionally ☐ seldom ☐ never

4. Do you experience the following problems?

   ☐ bad breath ☐ bleeding gums ☐ loose teeth ☐ joint pain

   ☐ food stuck between teeth ☐ oral habits: nail/pen biting etc.

   ☐ jaw clicking upon opening/closing your mouth

5. Have you been told that you grind your teeth? ☐ Yes ☐ No

6. Do you wake up in the morning with a feeling of tired jaws?

   ☐ Yes ☐ No

7. Do you clench your teeth? ☐ Yes ☐ No

8. Do you wear a night guard? ☐ Yes ☐ No

9. How often do you consume acid foods like citrus fruit, juice, pop?

   ☐ daily ☐ ____x a week ☐ occasionally

10. When was your last dental scaling/cleaning ______________________________

11. When were your last dental X-rays taken? ______________________________

12. How often do you usually have dental check-ups? Every:

    ☐ 3-4 months ☐ 6 months ☐ 9 months ☐ less often

13. What kind of toothbrush do you use?

    Manual: ☐ hard ☐ soft

    Electric ☐

14. Do you use mouthwash? ☐ Yes ☐ No

15. How often do you floss? ☐ rarely ☐ x a week _____ ☐ daily

16. Have you ever had?

    ☐ fillings ☐ root canal ☐ implants

    ☐ extractions ☐ dentures ☐ gum surgery

    ☐ head trauma ☐ TMJ problem ☐ orthodontic treatment

    ☐ wisdom teeth removal ☐ crowns/bridges

17. Are you satisfied with the colour of your teeth? ☐ Yes ☐ No

18. Would you consider sedation for dental treatment?

    ☐ Yes ☐ No

PAYMENT OPTIONS:

VISA, MASTERCARD, DEBIT, CHEQUES and CASH

WE ACCEPT DIRECT PAYMENTS FROM YOUR DENTAL INSURANCE COMPANY UNDER CERTAIN CONDITIONS:

1. We can verify your coverage details.

2. Policy is assignable (payable directly to dentist).

3. You provide us with a credit card to be used for all expenses not covered by your dental insurance.

For your convenience we offer deferred payment plans. Please inquire at front desk.

We use EDI. We do (on your request) submit insurance claims electronically to your insurance provider.

ELECTRONIC COMMUNICATION

We send emails to remind patients about future appointments, book and confirm appointments, verify insurance information. We require your consent to use this form of communication. You can revoke your consent at any time.

Do you consent to receiving electronic communication from Dental Care Centre?

☐ Yes, email address____ ☐ No

________________________________ ________________________________

Patient's signature Date

________________________________ ________________________________

DDS' signature Date

DENTAL CARE CENTRE

Dr. Monika Kiepas & Dr. David Burman

81 St. Clair Avenue East, Toronto, Ontario, M4T 1M7 Phone: (416) 961-8778 Fax: (416) 961-5776