Dental Care Centre

81 St. Clair Avenue East, M4T 1M7 − (416) 961-8778

dcconline@rogers.com

PERSONAL INFORMATION

Title _____ Family Name _____ First Name _____

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

Address _____

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. What conditions are you taking the medications for? _____

   _____

5. Do you have any allergies? ☐ Yes ☐ No ☐ Not Sure

   If yes, please list, using categories below:

   Medications ☐ _____

   Latex/Rubber Products ☐ _____

   Other (Hay-fever, foods) ☐ _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections?

   ☐ Yes ☐ No ☐ Not Sure

   If yes, please explain: _____

7. Do you have or have you ever had asthma?

   ☐ Yes ☐ No ☐ Not Sure

8. Do you have or have you ever had any heart or blood pressure problem?

   ☐ Yes ☐ No ☐ Not Sure

9. Do you have an artificial heart valve?

   ☐ Yes ☐ No ☐ Not Sure

10. Do you have a prosthetic or artificial joint?

    ☐ Yes ☐ No ☐ Not Sure

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

12. Do you have any conditions or therapies that could affect your immune system (e.g. Leukemia, AIDS, HIV, radiotherapy, chemotherapy)?

    ☐ Yes ☐ No ☐ Not Sure

13. Have you ever had hepatitis, jaundice or liver disease?

    ☐ Yes ☐ No ☐ Not Sure

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

15. Have you ever been hospitalized for any illnesses or operations?
☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

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

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

17. Are there any conditions or diseases not listed above that you have or have had?
☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

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

If yes, how many times per day? _____

19. Do you use any cannabis products? ☐ Yes ☐ No

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

21. ***For women only:*** Are you breast-feeding or pregnant?
☐ Yes ☐ No ☐ Not Sure

If pregnant, what is expected delivery date? _____

22. Do you identify as a patient with disability? ☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

_____

Name of Family Physician:

_____

Phone #: _____

Patient or 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 any of 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 color 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. You agree to cover all charges for procedures not included in your policy.
2. You agree to cover all charges in excess of your policy annual limit.

   (Please note, this is **YOUR** responsibility to track insurance spending)
3. Policy is **assignable** (payable directly to dentist). Please sign below:

   I hereby assign my benefits, payable from claims submitted electronically to Dr. Monika Kiepas and authorize payment directly to her. This authorization shall continue in effective until the undersigned revokes the same.

   Patient Signature: _____

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.

Patient Signature: _____ Date: _____

ELECTRONIC COMMUNICATION

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

email address: _____

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

DENTAL CARE CENTRE

Dr. Monika Kiepas

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