Orchard Heights DENTAL CENTRE
Family, Cosmetic and Implant Dentistry

St. Andrews Shopping Centre
2 Orchard Heights Blvd. Unit 45
Aurora Ontario L4G 3W3

Tel: (905) 727-8586 | Fax: (905) 727-4283 | Email: info@orchardheightsdental.ca

Patient Information - Adult

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain in this office.

First name: Last name: Middle name:

Date of Birth (dd/mm/yyyy) Sex : ☐ Male ☐ Female

Marital Status: ☐ married ☐ single ☐ divorced

Address : Street : Town :

Province : Postal Code :

Contact Info : Home Phone : Work Phone :

Cell Phone : **Email Address :**

In Case of Emergency, please notify :

Name : Relationship :

Address : Telephone :

Whom may we thank for referring you?

Insurance Information

Name of person responsible for account :

Address : Street : Town :

Province : Postal Code :

Occupation : Business Phone : Employer :

Dental Ins. : ☐ Yes ☐ No Name of Company :

Ins. Policy # : Employee I.D. #

Dental Insurance Subscriber :

Name : Date of Birth (dd/mm/yyy) :

☐ Yes ☐ No I authorize release to my insurance company plan administrator the information contained in claims submitted electronically.

Confidential Medical History

1. Are you presently, or within the past year, under treatment for a medical condition ?

☐ Yes ☐ No - Reason :

2. Family Physician: - Phone:

3. Are you presently taking any pills, drugs or medication?

☐ Yes ☐ No -Details :

4. Have you taken any prolonged medication in the past? Prescription or non-prescription?

☐ Yes ☐ No - Details :

5. Have you heart disease, murmur, a congenital heart defect or an artificial heart valve?

☐ Yes ☐ No - Details :

6. Have you had abnormal bleeding?

☐ Yes ☐ No - Details :

7. Have you any allergies (food, latex, rubber) ?

☐ Yes ☐ No - Details :

8. Have you allergies to any drugs or medication? (ie. Codeine/Penicillin)

☐ Yes ☐ No - Details :

9. Have you ever been hospitalized and was surgery performed?

☐ Yes ☐ No - Details :

10. Do you have or have your had? (please check)

☐ High Blood Pressure	☐ Diabetes	☐ Asthma	☐ Kidney Trouble
☐ Low Blood Pressure	☐ Liver Trouble	☐ Rheumatic Fever	☐ Shortness of Breath
☐ Nervous Problems	☐ Hepatitis	☐ Sinus Problems	☐ Radiation Treatment
☐ Thyroid Problems	☐ Blood Disorders	☐ Stroke	☐ Psychiatric Care
☐ Are you Pregnant?	☐ H.I.V.	☐ Tuberculosis	☐ Venereal Disease
☐ Heart Trouble	☐ Herpes	☐ Ulcer	☐ Scarlet Fever
☐ Chest Pain	☐ Cancer	☐ Fainting Spells	☐ Epilepsy
☐ Anemia	☐ Arthritis		

11. Are you currently in good health? ☐ Yes ☐ No

12. Is there anything else you think you should tell me?

Confidential Dental Information

1. Previous dentist: Phone:

2. Are you having any discomfort at this time? ☐ Yes ☐ No - Details :

3. How long since your last dental visit?

4. What was done at that time?

5. Do your gums feel tender or swollen? ☐ Yes ☐ No - Details :

6. Have you ever been given local anesthetic?(freezing) ☐ Yes ☐ No - Details :

7. Any complications with # 6? ☐ Yes ☐ No - Details :

8. Are you aware of any lump or swelling in your mouth? ☐ Yes ☐ No - Details :

9. Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No - Details :

10. Are you tense during dental visits? ☐ Yes ☐ No - Details :

11. Please list any other conditions that you have not mentioned above.

12. Do you currently experience: (please check)

☐ loose teeth	☐ neck pain	☐ spaced or crooked teeth	☐ headache
☐ sore gums	☐ unexplained nosebleed	☐ bad breath	☐ gagging
☐ ear ache	☐ missing teeth	☐ unsatisfactory dentures	
☐ sensitive teeth	☐ bleeding gums	☐ popping or clicking in the jaw joints	

If Yes, describe :

Additional Information

Describe in your own words what you would like done with your teeth:

CONSENT FOR TREATMENT

This certifies that I the undersigned, consents to the agreed upon, necessary, or advisable dental procedures.I will assume full responsibility for the fees associated with these procedures.

Signature : Date :