

st andrews DENTAL

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Get Acquainted Questionnaire

In order that we may better serve you, please fill in the following information:

Name _____ ☐ Mr. ☐ Mrs. ☐ Miss Date of birth _____
Last First Middle

Residence _____
Street Apt. City Postal Code

Employer _____ Occupation _____

Residence Tel # _____ Business Tel # _____ Cell # _____

Email _____

Social Insurance No. _____ Drivers Licence No. _____

Whom may we thank for referring you to our office? _____

Person to contact in the event of an emergency:

Name _____ Relationship to patient _____

Address _____

Residence Tel # _____ Business Tel # _____ Cell # _____

Your Health History

Physician _____ Address _____ Tel# _____

Date of last complete medical examination _____

Under medical treatment now or within the last year _____

Hospitalized of any serious illness _____

Please indicate if you have had any of the following. If yes, please fill in details

☐ Yes ☐ No Heart Trouble _____

☐ Yes ☐ No Pain in chest/shortness of breath after mild exertion _____

☐ Yes ☐ No Rheumatic fever or Heart murmur _____

Please Turn Over →

- ☐Yes ☐No Congenital Heart lesions _____
- ☐Yes ☐No Diabetes _____
- ☐Yes ☐No Hepatitis _____
- ☐Yes ☐No Kidney Trouble _____
- ☐Yes ☐No Blood Disorders _____
- ☐Yes ☐No Does your occupation or social environment put you in jeopardy of contracting a sexually transmitted disease, herpes, or the AIDS virus? _____
- ☐Yes ☐No Epilepsy _____
- ☐Yes ☐No Convulsions _____
- ☐Yes ☐No Fainting _____
- ☐Yes ☐No Gastrointestinal disorders _____
- ☐Yes ☐No Tuberculosis/lung disease _____
- ☐Yes ☐No Arthritis/Joint replacement _____
- ☐Yes ☐No Allergies (hay fever, rash, asthma) _____
- ☐Yes ☐No Physical or psychological disabilities or conditions _____
- ☐Yes ☐No Snoring/sleep apnea/sleep disturbances _____
- ☐Yes ☐No Drug/alcohol addiction _____
- ☐Yes ☐No Using any medicine or herbal remedies (pills, tablets, shots, drops, ointments, birth control pills, insulin, anticoagulant, cortisone, aspirin) _____

Allergic to or any unusual reaction to:

- | | |
|--|--|
| ☐ Novocaine/dental anaesthetics _____ | ☐ Codeine _____ |
| ☐ Penicillin/antibiotics _____ | ☐ Aspirin _____ |
| ☐ Sulfa _____ | ☐ Tranquilizers _____ |

Other _____

- ☐ Any Illness treated by radiation therapy/chemotherapy? ☐Any Osteoporosis medications?
- ☐Are your pregnant now? _____ Due Date? _____
- ☐Do you smoke? _____ Amount _____

Blood Pressure: _____ Date: _____

Your Dental Health History

Who was your last dentist? _____ For how Long? _____

When was your last dental appointment? _____ Date of last dental cleaning? _____

What dental treatment was completed? _____

☐ Yes ☐ No Have you had dental x-rays in the last year? _____

☐ Yes ☐ No Do you have areas of your gums that bleed easily? _____

☐ Yes ☐ No Have you ever had abnormal bleeding associated with extractions? _____

☐ Yes ☐ No Do you have frequent cold sores or canker sores? _____

☐ Yes ☐ No Is any part of your mouth sensitive to temperature or pressure? _____

☐ Yes ☐ No Have you ever had gum (periodontal) treatment? When? _____

☐ Yes ☐ No Have you ever worn braces to straighten your teeth? _____

☐ Yes ☐ No Do you clench or grind your teeth during the day or night? _____

☐ Yes ☐ No Do you ever have migraine headaches? _____

☐ Yes ☐ No Have you ever had dental implant surgery? If yes, who performed the surgery and when?

☐ Yes ☐ No Are you being followed up by a dental specialist? _____

If you are wearing a partial or complete denture, please complete the following:

For what reason were the teeth lost? _____

Approximate date of extractions? _____

Has your denture been relined? _____ When? _____

How old is your present appliance? Upper _____ Lower _____

Are you satisfied with the appearance? _____ Comfort? _____

Why are you seeking dental care at this time? _____

Do you feel that your dental problems are serious? _____

Are you happy with the appearance of your teeth? If not, why? _____

What are your sports interests, general interests, or hobbies? _____

Please Turn Over →

FINANCIAL POLICY

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are please to offer you these options for payment:

VISA, Master Card, AMEX, Debit.

Please be advised payment is due the day of service.

We will as a courtesy, process your insurance benefits in our office, which will relieve you of this time consuming and sometimes complicated task.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. We kindly ask that you provide at least two full business days' notice if you need to change or cancel your appointment. This allows us to offer time to another patient who may be waiting. We appreciate your understanding and consideration!

Signature (responsible party)

Date

Dentist Signature

Date