MEDICAL ALERTS: _____

WELCOME TO SELWYN FAMILY DENTAL

DATE:_____

PATIENT INFORMATION

NAME:_____ **DOB(M/D/Y):** _____ **GENDER: M / F**
HEALTH CARD NUMBER:_____ **APPROVAL FOR TEXT/EMAIL REMINDERS: Yes/ No**
ADDRESS: _____**POSTAL CODE**_____
PHONE:_____ **CELL:**_____ **EMAIL:**_____
PERSON TO CONTACT INCASE OF EMERGENCY: _____**PHONE:**_____
HOW DID YOU HEAR ABOUT OUR OFFICE?_____

INSURANCE INFORMATION

NAME OF INSURED: _____ **DOB(M/D/Y):**_____
EMPLOYER: _____ **GROUP/POLICY #:**_____ **CERTIFICATE #:**_____
DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING:
NAME OF INSURED: _____ **DOB(M/D/Y):**_____
EMPLOYER: _____ **GROUP/POLICY #:**_____ **CERTIFICATE #:**_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

Aspirin Ibuprofen Acetaminophen Codeine Penicillin Erythromycin Tetracycline Sulpha
Local Anesthetic Fluoride Metals (Nickel, Gold, Silver, _____) Latex

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING

	YES	NO
HOSPITALIZED FOR ILLNESS OR INJURY IN THE PAST 5 YEARS	☐	☐
HEART PROBLEMS OR CARDIAC STENT WITHIN LAST 6 MONTHS	☐	☐
UNDERGOING OR HAVE HAD RADIATION THERAPY	☐	☐
UNDERGOING OR HAVE HAD CHEMOTHERAPY	☐	☐
ARTIFICIAL PROSTHESIS, OR HEART VALVE	☐	☐
HIGH OR LOW BLOOD PRESSURE(please circle)	☐	☐
INFECTIVE ENDOCARDITIS	☐	☐
A STROKE	☐	☐
ANEMIA OR OTHER BLOOD DISORDER	☐	☐
KIDNEY DISEASE	☐	☐
HEPATITIS (TYPE____), LIVER DISEASE?	☐	☐
THYROID /PARATHYROID DISEASE	☐	☐
HIGH CHOLESTEROL	☐	☐
BISPHOSPHONATES/BONE STRENGTHENER USE	☐	☐
TAKING BLOOD THINNERS	☐	☐

	YES	NO
DIABETES (CIRCLE) TYPE I / TYPE II	☐	☐
DIGESTIVE DISORDERS	☐	☐
ARTHRITIS/OSTEOPOROSIS	☐	☐
HEAD, BACK OR NECK INJURIES	☐	☐
EPILEPSY, CONVULSIONS (SEIZURES)	☐	☐
NEUROLOGICAL PROBLEMS	☐	☐
ANTIDEPRESSANT MEDICATION	☐	☐
VIRAL INFECTIONS AND COLD SORES	☐	☐
ASTHMA OR HAY FEVER	☐	☐
EMPHYSEMA, SARCOIDOSIS	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
HIV / AIDS	☐	☐
ALCOHOL / DRUG DEPENDENCY	☐	☐
CIGARETTE SMOKER (HOW LONG____)	☐	☐
CANNABIS SMOKER (HOW LONG____)	☐	☐
WOMEN ONLY:		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐

FLIP OVER

MEDICAL ALERTS: _____

	YES	NO
FAMILY PHYSICIAN _____ _____		
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR ILLNESS ……	☐	☐
PLEASE EXPLAIN :_____		
DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED THAT YOU THINK I SHOULD KNOW ABOUT ……	☐	☐

	YES	NO
ARE YOU TAKING ANY MEDICATIONS ……	☐	☐

PLEASE LIST THEM:

MEDICATION	PURPOSE	DOSAGE

PATIENT DENTAL HISTORY

REASON FOR THIS VISIT: _____

WHEN WAS YOUR LAST DENTAL VISIT: _____ WHAT WAS DONE:_____

HOW OFTEN DID YOU VISIT THE DENTIST:_____ PREVIOUS DENTIST:_____

LAST X-RAYS:_____ HOW OFTEN DO YOU BRUSH/FLOSS: _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING……	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT, COLD OR SWEET LIQUIDS/FOODS……	☐	☐
DO YOU HAVE ANY JAW/JOINT PROBLEMS……	☐	☐
DO YOU HAVE FREQUENT HEADACHES…….	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH……	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH……	☐	☐
HAVE YOU EVER HAD PERIODONTAL(GUM) TREATMENT……	☐	☐
DO YOU WEAR DENTURES OR PARTIALS……	☐	☐
WOULD YOU CONSIDER YOUSELF A NERVOUS DENTAL PATIENT……	☐	☐

	YES	NO
HAVE YOU EVER EXPERIENCED GUM RECESSION……	☐	☐
DO YOU CHEW ICE, BITE YOUR NAILS OR HOLD THINGS WITH YOUR TEETH……	☐	☐
HAVE YOU EVER NOTICED AN UNPLEASANT TASTE OR ODOUR IN YOUR MOUTH ……	☐	☐
ARE YOU FEARFUL OF THE DENTIST ……	☐	☐

PLEASE RATE ON A SCALE OF 1(LEAST) 10(MOST) _____

APPEARANCE

IS THERE ANYTHING ABOUT THE APPEARANCE OF YOUR TEETH THAT YOU WOULD LIKE TO CHANGE ?

_____

_____

I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history and have not knowingly omitted any information. Should there be any change in my health status in the future, I will advise this to the dental staff. I hereby assign my benefits payable from claims submitted electronically to the dentist and authorize payment directly to him/her; unless otherwise arranged. Privacy policies that protect my personal health information are available upon request at reception.

Patient's Signature : _____ Date: _____

Dentist's Signature : _____