

# Welcome To Our Practice

## NEW PATIENT INFORMATION FORM



MILL BAY  
DENTAL HEALTH  
AND IMPLANT CENTRE

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Personal Health Number (Care Card): \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

How do you prefer to be contacted?     Cell     Home Phone     Email     Work Phone:

Who do we call in case of emergency?    Name: \_\_\_\_\_    Phone: \_\_\_\_\_

Who can we thank for referring you (how did you find out about our practice)?:

Patient: \_\_\_\_\_ (Relationship) \_\_\_\_\_     Website

Online / Google Search     News Paper Ad     Walk by     External Signage

Social Media

### Insurance Information

Insurance Carrier: \_\_\_\_\_ Policy number: \_\_\_\_\_

ID number: \_\_\_\_\_     Subscriber     Insured

### Personal History

It is important to us that we meet your needs and address your primary concerns therefore we ask you to share the following information leading into your appointment today:

What is your primary concern today: \_\_\_\_\_

When did this become a concern: \_\_\_\_\_

How would you describe your last dental experience: \_\_\_\_\_

What prevented you from returning to your former Dentist?: \_\_\_\_\_

I routinely see my dentist every:     3 mo.     4 mo.     6 mo.     12 mo.     Not routinely

Do you have or have you ever had ever have Braces, Orthodontics, Treatment or Upper Bite Adjustment?:     Yes     No

*Treating everyone like family*

PO Box 105, Suite 380 2720  
Mill Bay BC  
V0R 2P0

T: 250-743-9511  
E: admin@millbaydental.ca  
www.millbaydental.ca

Please answer Yes or No to the following:

**YES**    **NO**

**Gum and Bone**

- Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_
- Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
- Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
- Have you ever experienced gum recession? \_\_\_\_\_
- Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_

**Tooth Structure**

- Have you had any cavities within the past 3 years? \_\_\_\_\_
- Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
- Do you frequently get food caught between any teeth? \_\_\_\_\_

**Smile Characteristics**

- Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_
- Have you ever whitened (bleached) your teeth? \_\_\_\_\_
- Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_
- Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Your Privacy is Always Assured**

Privacy of our patient’s personal information is important to us. Personal information is necessary for providing professional oral health care services to you and information necessary to administer your dental treatment.

I authorize communication of this personal information by mail, electronic and verbal means. Personal information includes clinical records, X-rays, study models, photographs of you and your teeth, mouth, smile and face, and general health information obtained from a medical history review, insurance information, phone numbers and email addresses. Clinical information and photographs, x-rays may also be used for long-term follow-up and research purposes, as well as for education or teaching purposes.

Your personal information will only be shared with those who have a need to know and specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include referring dentists, other dental specialists, physician(s), dental laboratories and insurance carriers.

I certify that I have read and understand this document.

Signature/Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature/Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?  Excellent  Good  Fair  Poor

Have you been instructed to take pre-medication prior to dental treatment? \_\_\_\_\_

<b>Do You Have or Have You Ever Had:</b>	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	20. thyroid, parathyroid disease, or calcium deficiency	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to:	<input type="checkbox"/>	<input type="checkbox"/>	21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			25. digestive disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfalocal			(i.e. celiac disease, gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> anesthetic			26. osteoporosis/osteopenia _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			(i.e. taking bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			28. autoimmune disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			(i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	33. neurologic disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	(ADD/ADHD, prion disease)	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
(i.e. sleep apnea, snoring, sinus)			42. biphosphonates _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	43. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>			

- 44. emotional difficulties \_\_\_\_\_  YES  NO
- 45. psychiatric treatment \_\_\_\_\_  YES  NO
- 46. antidepressant medication \_\_\_\_\_  YES  NO
- 47. alcohol / recreational drug use \_\_\_\_\_  YES  NO

- 55. currently pregnant \_\_\_\_\_  YES  NO
- 56. prostate disorders \_\_\_\_\_  YES  NO

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections).

**Are You:**

- 48. presently being treated for any other illness \_\_\_\_\_  YES  NO
- 49. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) \_\_\_\_\_  YES  NO
- 50. taking dietary supplements \_\_\_\_\_  YES  NO
- 51. often exhausted or fatigued \_\_\_\_\_  YES  NO
- 52. experiencing frequent headaches \_\_\_\_\_  YES  NO
- 53. a smoker, smoked previously or use smokeless tobacco \_\_\_\_\_  YES  NO
- 54. taking birth control pills \_\_\_\_\_  YES  NO

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**List all medications, supplements, and or vitamins taken within the last two years.**

Please advise us in the future of any change in your medical history or any medications you may be taking.

Drug	Purpose	Drug	Purpose

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_