ARCHER DENTAL

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Patient Medical History & Information Form

Salutation _____ Last Name_____ First Name _____

Preferred Name _____ Date of Birth _____ Sex _____

Address _____ Unit # _____ City/Province_____

Postal Code _____ Telephone number _____ Alt number _____

May we contact you by e-mail? Yes☐ No ☐ E-mail address _____

How did you hear about us? _____

Emergency Contact _____ Phone number _____

CASL consent - I consent to communicating with this dental office and receiving important information from this office by email, text messaging or social media. This office is committed to never sending spam email and will always take all reasonable precautions to protect my electronic information.

Signature : _____

Insurance Information

Insurance Company _____ Group # _____Cert# _____
Name of Insured _____ DOB _____ Relationship _____

Do You Have Any Additional Insurance? If yes, complete the following:

Insurance Company _____ Group # _____Cert# _____
Name of Insured _____ DOB _____ Relationship _____

Medical History

What is your estimate of your general health? (please select) Excellent
Have you ever been hospitalized for illness or injury? ☐Yes☐No
Please specify _____
Are presently being treated for any other illness? ☐Yes☐No
Please specify _____
Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ☐Yes☐No
Taking medication for weight management? Taking dietary supplements? ☐Yes☐No
Often exhausted or fatigued? ☐Yes☐No
Experiencing frequent headaches ☐Yes☐No
A smoker, smoked previously or use smokeless tobacco? ☐Yes☐No
Considered a touchy/sensitive person ☐Yes☐No
Often unhappy or depressed ☐Yes☐No
Taking birth control pills ☐Yes☐No
Currently pregnant ☐Yes☐No
Diagnosed with a prostate disorder ☐Yes☐No

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Have you had an **allergic** or **bad reaction** to any of the following (please select) ☐Yes ☐No

☐ aspirin	☐ ibuprofen	☐ acetaminophen
☐ codeine	☐ sulfa	☐ latex
☐ penicillin	☐ local anesthetic	☐ nuts
☐ erythromycin	☐ fluoride	☐ fruit
☐ tetracycline	☐ metals (nickel, gold, silver)	☐ other_____

DO YOU HAVE or HAVE YOU EVER HAD:

Heart problems, or cardiac stent	☐Yes ☐No	Digestive disorders (celiac, crohn's etc)	☐Yes ☐No
History of infective endocarditis	☐Yes ☐No	Eating disorders (bulimia, anorexia etc)	☐Yes ☐No
Artificial heart valve, repaired heart defect (PFO),		Osteoporosis/osteopenia	☐Yes ☐No
Pacemaker or implantable defibrillator	☐Yes ☐No	Arthritis	☐Yes ☐No
Orthopedic implant (joint replacement)	☐Yes ☐No	Autoimmune disease	☐Yes ☐No
Rheumatic or scarlet fever	☐Yes ☐No	Glaucoma	☐Yes ☐No
High or low blood pressure	☐Yes ☐No	Head or neck injuries	☐Yes ☐No
A stroke (taking blood thinners)	☐Yes ☐No	Epilepsy, convulsions (seizures)	☐Yes ☐No
Anemia or other blood disorder	☐Yes ☐No	Neurologic disorders (ADD/ADHD, etc)	☐Yes ☐No
Prolonged bleeding (INR > 3.5)	☐Yes ☐No	Viral infections and cold sores	☐Yes ☐No
Pneumonia, emphysema, shortness of breath, sarcoidosis	☐Yes ☐No	Any lumps or swelling in the mouth	☐Yes ☐No
		Hives, skin rash, hay fever	☐Yes ☐No
Tuberculosis, measles, chicken pox	☐Yes ☐No	STI/STD/HPV	☐Yes ☐No
Asthma	☐Yes ☐No	Hepatitis (type ___)	☐Yes ☐No
Breathing or sleep problems		HIV/AIDS	☐Yes ☐No
(i.e. sleep apnea, snoring, sinus)	☐Yes ☐No	Tumor, abnormal growth	☐Yes ☐No
Kidney disease	☐Yes ☐No	Radiation therapy	☐Yes ☐No
Liver disease/jaundice	☐Yes ☐No	Chemotherapy, immunosuppressive medication	☐Yes ☐No
Thyroid, parathyroid disease, calcium deficiency	☐Yes ☐No	Emotional difficulties	☐Yes ☐No
Hormone deficiency	☐Yes ☐No	Psychiatric treatment	☐Yes ☐No
High cholesterol or taking statin drugs	☐Yes ☐No	Antidepressant medication	☐Yes ☐No
Diabetes (HbA1c =)	☐Yes ☐No	Alcohol/recreational drug use	☐Yes ☐No
Stomach or duodenal ulcer	☐Yes ☐No		

Name of Physician/and their specialty _____ Most recent physical examination _____

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) _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

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

_____ _____

_____ _____

_____ _____

_____ _____

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Dental History

Referred by How would you rate the condition of your mouth? (please select) Excellent

Previous Dentist _____ How long have you been a patient? Months/Years _____

I routinely see my dentist every: (please select) 3 mo.

Date of last visit _____ Date of last Xrays _____

WHAT IS YOUR IMMEDIATE CONCERN? _____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]

Have you had an unfavorable dental experience? ☐Yes☐No

Have you ever had complications from past dental treatment? ☐Yes☐No

Have you ever had trouble getting numb or had any reactions to local anesthetic? ☐Yes☐No

Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ☐Yes☐No

Have you had any teeth removed, missing teeth or lost teeth due to injury or facial trauma? ☐Yes☐No

Do your gums bleed or are they painful when brushing or flossing? ☐Yes☐No

Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐Yes☐No

Have you ever noticed an unpleasant taste or odor in your mouth? ☐Yes☐No

Is there anyone with a history of periodontal disease in your family? ☐Yes☐No

Have you ever experienced gum recession? ☐Yes☐No

Have you ever had any teeth become loose on their own (without an injury)? ☐Yes☐No

Have you experienced a burning or painful sensation in your mouth not related to your teeth? ☐Yes☐No

Have you had any cavities within the past 3 years? ☐Yes☐No

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ☐Yes☐No

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ☐Yes☐No

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ☐Yes☐No

Do you have grooves or notches on your teeth near the gum line? ☐Yes☐No

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ☐Yes☐No

Do you frequently get food caught between any teeth? ☐Yes☐No

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ☐Yes☐No

Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ☐Yes☐No

Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ☐Yes☐No

In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ☐Yes☐No

Are your teeth becoming more crooked, crowded, or overlapped? ☐Yes☐No

Are your teeth developing spaces or becoming more loose? ☐Yes☐No

Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ☐Yes☐No

Do you place your tongue between your teeth or close your teeth against your tongue? ☐Yes☐No

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐Yes☐No

Do you clench or grind your teeth together in the daytime or make them sore? ☐Yes☐No

Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ☐Yes☐No

Do you wear or have you ever worn a bite appliance? ☐Yes☐No

Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ☐Yes☐No

Have you ever whitened (bleached) your teeth? ☐Yes☐No

Have you felt uncomfortable or self-conscious about the appearance of your teeth? ☐Yes☐No

Have you been disappointed with the appearance of previous dental work? ☐Yes☐No

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Photography

I consent to photography, filming, and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Patient/Guardian Signature: _____

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

_____ _____

Date Signature

Consent for Collection, Use and Disclosure of Personal Information

I agree that Archer Dental has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy and is in accordance with the Personal Health Information Protection Act, 2004.
