Forestbrook Dental
FAMILY & COSMETIC DENTISTRY

3985 Highway 7 East, Unit 102 Markham, ON L3R 2A2
T. 905-305-8872 office@forestbrookdental.com

Patient Information

Welcome to Forestbrook Dental! In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

A parent or guardian will be responsible for decisions on my treatment ☐ Yes ☐ No

Name: ______________________________
First Initial Last

Address: ______________________________
Street Apt. City Prov. Postal Code

Date of Birth: ______/______/______ Email Address: ______________________________
D M Y

Home Phone: (______) ______________ Cell Phone: (______) ______________ Work Phone: (______) ______________

How did you hear about us?______________________________

Emergency Contact: ______________________________ Tel. (______) ______________

Family Doctor: ______________________________ Tel. (______) ______________

Specialist Doctor: ______________________________ Tel. (______) ______________

Financial Information

Method of payment: Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐

Person responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

PRIMARY INSURANCE

Ins. Company:______________________________ Tel. (______) ______________

Employer/Policy Holder: ______________________________ Ins. Yr. End: ______________

Policy#: ______________ Certificate#: ______________ ID#: ______________

SECONDARY INSURANCE

Ins. Company:______________________________ Tel. (______) ______________

Employer/Policy Holder: ______________________________ Ins. Yr. End: ______________

Policy#: ______________ Certificate#: ______________ ID#: ______________

Dental History

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other ______________
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other ______________
3. When was your last dental visit? ______________ Last X-Ray? ______________
4. How often do you brush per day? ______________ Floss? ______________ Use anti-bacterial rinse? ______________
5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other ______________
6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never

	YES	NO
7. Do your gums feel swollen or tender?	☐	☐
8. Do you have bad breath or a bad taste in your mouth?	☐	☐
9. Do your jaws crack, pop or grate when you open widely?	☐	☐
10. Do you grind or clench your teeth?	☐	☐
11. Do you have food catch between your teeth?	☐	☐
12. Have you ever had local anaesthetic (freezing)? Any complications? ☐ Yes ☐ No Specify ______________	☐	☐
13. Have you ever had any problems with previous dental treatments? Specify______________	☐	☐

14. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps ☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gums) ☐ Root Canal

15. Are you satisfied with your teeth? Specify ______________	☐	☐

Medical History

This information will remain CONFIDENTIAL. Date:____________________

	YES	NO
1. Are you presently under the care of a physician? If so, explain.________________	☐	☐
2. Have you ever been hospitalized? Explain. ________________	☐	☐
3. Are you taking any drugs or medications at this time?	☐	☐

[A] Drug ____________ Reason ____________ [D] Drug ____________ Reason ____________
[B] Drug ____________ Reason ____________ [E] Drug ____________ Reason ____________
[C] Drug ____________ Reason ____________ [F] Drug ____________ Reason ____________

4. Have you ever had any adverse effect to any of the following: **Antibiotics: Penicillin** ☐ , **Sulfonamide** ☐ , **Other** ☐ ;
Aspirin ☐ ; **Barbiturates (sleeping pills)** ☐ ; **Codeine** ☐ ; **Darvon** ☐ ; **Local Anaesthetic** ☐ ; **NONE** ☐

	YES	NO
5. Have you ever been warned against using any other medications? Which? ________________	☐	☐
6. Have you ever taken prolonged medical or non-medical drugs? Which? ________________	☐	☐
7. Do you suffer from any allergies (hay fever, latex etc.)? Which? ________________	☐	☐
8. Do you bruise easily or have prolonged bleeding?	☐	☐
9. Do you smoke? How much per day? ____________	☐	☐
10. Have you ever fainted, had shortness of breath or chest pains?	☐	☐

11. **WOMEN** Are you pregnant? Yes ☐ No ☐ Using birth control? Yes ☐ No ☐ Reached menopause? Yes ☐ No ☐

12. Do you have or have you ever had any of the following? Please ✔ appropriate boxes. NONE ☐

☐ **A.I.D.S.**	☐ **Cortisone/steroid**	☐ **High/Low Blood pressure**	☐ **Psychiatric disorders**
☐ **Anemia**	☐ **Diabetes**	☐ **H.I.V. Positive**	☐ **Radiation/Chemotherapy**
☐ **Angina pectoris**	☐ **Drug/alcohol dependence**	☐ **Hodgkin disease**	☐ **Rheumatic/Scarlet fever**
☐ **Anorexia nervosa**	☐ **Emphysema**	☐ **Hyper (Hypo) Glycemia**	☐ **Sickle Cell disease**
☐ **Artificial Heart valve**	☐ **Epilepsy**	☐ **Hypertension**	☐ **Sinus trouble**
☐ **Arthritis/rheumatism**	☐ **Glandular disorders**	☐ **Jaundice**	☐ **Stomach/intestinal issues**
☐ **Artificial joints (hips, knees)**	☐ **Glaucoma**	☐ **Kidney disease**	☐ **Stroke**
☐ **Asthma**	☐ **Head/Neck injuries**	☐ **Liver disease**	☐ **Thyroid disease**
☐ **Blood disorders**	☐ **Heart disease/attack**	☐ **Leukemia**	☐ **Tuberculosis**
☐ **Bronchitis**	☐ **Heart murmur**	☐ **Lung disease**	☐ **Ulcers**
☐ **Bulimia**	☐ **Heart pacemaker/surgery**	☐ **Malignant hypothermia**	☐ **Venereal disease**
☐ **Cancer**	☐ **Heart rhythm disorder**	☐ **Mental/nervous disorder**	☐ **Other** ____________
☐ **Circulation problems**	☐ **Hepatitis A/B/C**	☐ **Mitral valve prolapse**	☐ **Other** ____________
☐ **Congenital heart lesions**	☐ **Herpes**	☐ **Organ transplant/implant**	☐ **Other** ____________

13. **CHILDREN** Have you recently had any of the following (approximate date)?

☐ Chicken Pox ____________ ☐ Measles ____________ ☐ Mumps ____________
☐ Strep Throat ____________ ☐ Tonsillitis ____________ ☐ NONE

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

____________________ ____________________ ____________
Signature ☐ Patient ☐ Parent/Guardian Print name Date

Thank You