DENTAL BENEFITS:

PRIMARY DENTAL BENEFITS:

INSURANCE COMPANY: ______________________________________

EMPLOYEE NAME: ____

PLAN HOLDERS DATE OF BIRTH (mm/dd/yyyy): _____/_____/______

RELATIONSHIP TO PLAN HOLDER: ______________________________

GROUP/PLAN NUMBER: ______________________DIV: ____________

ID/CERTIFICATE NUMBER: ____________________________________

SECONDARY DENTAL BENEFITS:

INSURANCE COMPANY: ______________________________________

EMPLOYEE NAME: ____

PLAN HOLDERS DATE OF BIRTH (mm/dd/yyyy): _____/_____/______

RELATIONSHIP TO PLAN HOLDER: ______________________________

GROUP/PLAN NUMBER: ______________________DIV: ____________

ID/CERTIFICATE NUMBER: ____________________________________

PLAN DETAILS:

PLEASE BRING YOUR BENEFIT DETAILS/PLAN BREAKDOWN TO YOUR FIRST APPOINTMENT SO WE WILL BE ABLE TO WORK DIRECTLY WITH YOUR BENEFIT PLAN. IF YOU ARE UNABLE TO BRING YOUR BENEFIT DETAILS/PLAN BREAKDOWN TO YOUR FIRST APPOINTMENT, WE WILL ASK YOU FOR PAYMENT AND OUR BUSINESS TEAM WILL BE HAPPY TO SUBMIT TO YOUR BENEFIT PLAN ON YOUR BEHALF, TO REIMBURSE YOU DIRECTLY.

DENTAL CENTRE

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR/MRS/MS/MISS/DR

DATE OF BIRTH (MONTH/DAY/YEAR): / /

HOME ADDRESS:

PHONE:

E MAIL ADDRESS:

NAME OF EMPLOYER:

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill the entire form.

1. Are you being treated for any medical condition at the present time or have you been treated within the past year? If so, why?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

2. When was your last medical checkup?

3.Has there been any change in your general health in the past year. If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

a) medication & antibiotics:

b) latex/rubber products:

c) other (e.g. hayfever, foods):

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

7. Do you have or have you ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

8. Do you have or have you ever had any heart or blood pressure problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV Infection, radiotherapy, chemotherapy? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

12. Have you ever had hepatitis (A,B,C or another form) jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

13. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

14. Have you ever been hospitalized for any illness or operations? If yes please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

15. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizure (epilepsy)	☐ osteoporosis medications (e.g. Fosamax Actonel)
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease	
☐ stroke	☐ heart murmur	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	
☐ shortness of breath	☐ glaucoma	☐ cancer	☐ arthritis	☐ drug/alcohol dependency	
		☐ herpes (oral/genital)			

---

16. Are there any conditions or diseases not listed above that you have or have had? If so what?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

18. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

19. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

20. FOR WOMEN ONLY: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct.

Patient/Parent/Guardian Signature: ______________________ **Date:** __________

Dentist Signature: ______________________ **Date:** __________

DENTIST'S NOTES

DENTAL QUESTIONNAIRE

la vita DENTAL CENTRE

DENTAL HISTORY: **PATIENT NAME:** ______________________

- When was your last dental visit? ______________________
- When did you last have dental x-rays? ______________________
- When was your last dental cleaning? ______________________
- Name of Previous Dentist: ______________________ Phone Number: ______________________
- How often do you brush your teeth? ______________________
- How often do you floss your teeth? ______________________
- What are your goals and/or priorities for your oral health?______________________

____

	YES	NOT SURE/MAYBE	NO
Have you been seeing a dentist regularly?	❑	❑	❑
Do any of your teeth ache?	❑	❑	❑
Have you ever been advised to take antibiotics before dental appointments?	❑	❑	❑
Do your gums bleed when you brush?	❑	❑	❑
Do you have any pain when you chew?	❑	❑	❑
Do you feel that you have bad breath?	❑	❑	❑
Are there any growths or sores in your mouth?	❑	❑	❑
Do you catch food in or around any of your teeth or gums?	❑	❑	❑
Do you grind or clench your teeth?	❑	❑	❑
Are any of your teeth moving or becoming loose?	❑	❑	❑
Do you have any pain or clicking in your jaw joints?	❑	❑	❑
Have you ever been in a vehicle accident or experienced any blows to your jaw?	❑	❑	❑
Have you ever had any implant surgery in one or both of your jaws?	❑	❑	❑

- If you answered “yes” to the last question, who performed the surgery and when was it done? ______________________

____

- Are you being followed up by a dental specialist? ______________________
- Have you previously had any of the following dental treatments:

❑ Orthodontic Treatment (braces) ❑ Periodontic Treatment (gums/bone) ❑ Oral Surgery (extractions)

❑ Endodontic Treatment (root canal) ❑ Crowns or Bridges ❑ Porcelain Veneers

❑ Tooth Whitening ❑ Bonding

- While having previous dental treatment, have your ever:

❑ Fainted? ❑ Had abnormal bleeding? ❑ Other complication?

SMILE EVALUATION:

- Do you like the way your teeth look? ❑ YES ❑ NO

  Explain: ______________________________
- Are you happy with the colour of your teeth? ❑ YES ❑ NO

  Explain: ______________________________
- Would you like for your teeth to be whiter? ❑ YES ❑ NO

  Explain: ______________________________
- Would you like your teeth to be straighter? ❑ YES ❑ NO

  Explain: ______________________________
- Do you have spaces between your teeth that you would like closed? ❑ YES ❑ NO

  If so where: ______________________________
- Would you like your teeth to be longer? ❑ YES ❑ NO

  If so, Upper ________ Lower __________ Both ___________ ?
- Do you like the shape of your teeth? ❑ YES ❑ NO

  Explain: ______________________________
- Do you have missing teeth that you would like to replace? ❑ YES ❑ NO

  Explain: ______________________________
- Do you have old silver fillings that you would like to replace with tooth-coloured fillings? ❑ YES ❑ NO

  Explain: ______________________________
- Do you feel you show too much gum when you smile? ❑ YES ❑ NO

  Explain: ______________________________
- If you could change anything about your smile, what would you change? ______________________________

  ____

Patient/Parent/Guardian Signature: ______________________________ Date: ______________

Dentist Signature: ______________________________ Date: ______________

DENTIST'S NOTES