Blackburn Shoppes Dental Centre

Patient Information

Last Name: ◯ Male ◯ Female

First Name:

Age:

Date of Birth MM/DD/YYYY

Occupation:

Parent/Guardian Name:

Language Preference:

Home Address:

Home Phone:

City:

Cell Phone:

Province:

Email:

Postal Code:

Work Phone:

Provide email if you consent to receiving emails for confirmations, patient appreciation events & other events or promotions. Your email will not be shared.

Marital Status:

Name of Spouse or family member:

Person Financially Responsible for Account:

Do you have dental insurance? ◯ Yes ◯ No

If yes, please provide:

Name of insurance company:

Group/Policy/Plan Number:

Policy holder's name:

Policy holder's date of birth: MM/DD/YYYY

ID or certificate number:

Are you covered by any other dental insurance? ◯ Yes ◯ No

If yes, please provide:

Name of insurance company:

Group/Policy/Plan Number:

Policy holder's name:

Policy holder's date of birth: MM/DD/YYYY

ID or certificate number:

Family Physician: Phone #: Date of last visit:

Other Specialist: Phone #: Date of last visit:

How did you find out about our office?

◯ Facebook ◯ Sign ◯ Postcard ◯ Newspaper ◯ Medical Hub ◯ Miniplus

What is the reason for your visit?

Whom may we thank for referring you:

Medical History

Are you in good health? ◯ Yes ◯ No

(If no, please explain)

Have you had any serious illnesses/hospitalizations In the past 2 years ◯ Yes ◯ No

(if yes, please explain)

Do you currently have, or have you ever been treated for the following:

Stroke	HIV/AIDS	Asthma	Autism
Rheumatic Fever	Hepatitis A, B or C	Arthritis	Nervous Disorders
Heart Murmur	Blood Diseases	Osteoporosis	Fainting or Dizziness
Mitral Valve Prolapse	Prolonged Bleeding	Glandular Problems	Frequent Headaches
Heart Disease/Attack	Diabetes	Emotional Problems	Epilepsy
Artificial Heart Valve	Kidney Disorder	Anxiety	Cancer
Artificial Joints (Hip/Knee)	Anemia	Angina	High Blood Pressure
Tuberculosis	Thyroid Disease	Chron's Disease	Other (Please specify)
Heart Pacemaker	Liver Disease	Psychiatric Disorder	

If you checked any of the above, please give details

List any medication now being taken:

1. 2. 3. 4.

5. 6. 7. 8.

List any allergies, drug allergies or sensitivities:

Please bring a recent medication list if extensive.

Have you ever reacted adversely to any of the following medications or injections?

◯ Codeine ◯ Penicillin ◯ Sulpha ◯ Aspirin ◯ Local or general anaesthetic ◯ Other

Do you smoke or chew tobacco? How often?

Are you allergic to Latex? ◯ Yes ◯ No

WOMEN are you pregnant? ◯ Yes ◯ No Breast feeding? ◯ Yes ◯ No

Have you ever needed monthly injections or oral bisphosphonate treatment for osteoporosis? ◯ Yes ◯ No

Have you ever been advised to take antibiotics before dental treatments? ◯ Yes ◯ No

Dental History

Have you ever had any injuries to the face, mouth or teeth? ◯ Yes ◯ No

Have you ever been treated for a jaw joint problem, including surgery? ◯ Yes ◯ No

Have you ever had any type of dental surgery? ◯ Yes ◯ No

Do you have any appliances, retainers, nightguard? ◯ Yes ◯ No

Do you have any habits (nail biting, lip biting, objects)? ◯ Yes ◯ No

Do you have frequent canker or cold sores? ◯ Yes ◯ No

Are you a mouth breather? While asleep? While awake? ◯ Yes ◯ No

Have you been informed of any missing or extra permanent teeth? ◯ Yes ◯ No

Do you grind or clench your teeth? ◯ Yes ◯ No

Do you have frequent headaches? ◯ Yes ◯ No

Do you have difficulty opening and/or closing your jaw? ◯ Yes ◯ No

Are you apprehensive towards dental visits? ◯ Yes ◯ No

How often do you brush your teeth?

How often do you floss or use a waterpick?

I hereby give Dr. Chantal Plant, Dr. Anastasia Tour and/or members of her team, permission to release information concerning my dental health to the family physician, dentist or other specialist as is deemed necessary from time to time. Such information includes radiographs (x-rays) and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment or treatment in progress. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I have read and understand this paragraph, and I authorize Dr. Chantal Plant, or Dr. Anastasia Tour to perform a complete evaluation on me.

Patient Signature: ____________________ **Doctor Signature:** ____________________