BLACKBURN SHOPPES
DENTAL CENTRE

Patient Information

Last Name: ◯ Male ◯ Female

First Name: Age:

Date of Birth 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:

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:

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? (Select all that apply)

☐ Referral ☐ Online Search ☐ Live Locally ☐ Office Signage ☐ Postcard
☐ Newspaper ☐ Social Media ☐ Other

Whom may we thank for referring you:

What is the reason for your visit?

Medical History

Do you currently have any health conditions? ◯ Yes ◯ No
(If yes, 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:

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

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? (Select all that apply)

☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Local or general anaesthetic ☐ Other

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

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? If "Yes", when was the surgery?	◯ Yes	◯ No
Do you chew/smoke tobacco? How many/often?	◯ Yes	◯ No
Do you use recreational or medicinal drugs? (Cannabis, Cocaine, Heroin, etc) How often?	◯ 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
Do you snore or have you been Diagnosed with sleep apnea?	◯ 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 any appliances, retainers, nightguard?	◯ Yes	◯ No
Do you have frequent headaches?	◯ Yes	◯ No
Do you have difficulty opening and/or closing your jaw?	◯ Yes	◯ No
Have you ever been advised to take antibiotics before dental treatments?	◯ Yes	◯ No
Are you apprehensive towards dental visits?	◯ Yes	◯ No
How often do you brush your teeth per day?		
How often do you floss?		
Do you use a waterpick?		

I hereby give Dr. Chantal Plant, and associates and/or members of the team, permission to release infomation 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, and associates to perform a complete evaluation on me.

Patient Signature **Doctor Signature** **Date**