New Patient Form

Patient Information

First Name *

Last Name *

Date of Birth *

Age

Gender *
- Male
- Female
- Other

Occupation

Language Preference

Parent/Guardian Name

Address *

Address 2

City *

Province *

Postal Code *
T5T 5T5

Home Phone
(___) ___-____

Cell Phone
(___) ___-____

Work Phone
(___) ___-____

Email

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

Family Physician

Phone Number
(___) ___-____

Date of last visit

Other Specialist

Phone Number
(___) ___-____

Date of last visit

How did you find out about our office?
- 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?

Do you have dental insurance?
- Yes
- No

Are you covered by any other dental insurance?

If yes, please provide:

Name of insurance company

Group/Policy/Plan Number

Policy holder’s name

Policy holder’s date of birth

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

ID or certificate number

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

(Please specify)

If you checked any of the above, please give details:

List any medication now being taken:

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

(Please specify)

Are you allergic to Latex?

○ Yes ○ No

Have you ever needed monthly injections or oral bisphosphonate treatment for osteoporosis?

○ Yes ○ No

WOMEN: Are you pregnant?
○ Yes ○ No

Breast feeding?
○ 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

If “Yes”, when was the surgery?

Do you chew/smoke tobacco?
○ Yes ○ No

How many/often?

Do you use recreational or medicinal drugs? (Cannabis, Cocaine, Heroin, etc)
○ 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?
○ Yes ○ No

○ While asleep?
○ While awake

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.

Signature

First & Last Name *

Date

Signature *

Sign above

Submit