# Personal Information

MAXWELL DENTAL

*Confidential Patient Record: The information requested on this questionnaire, dental history and medical history is essential to providing you with the safest and highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collection, using and disclosing this information responsibly.*

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Adult ☐Child

Legal Name: _____ Preferred Name: _____

Birthdate: _____ Age: _____ Marital Status: ☐Single ☐Married ☐Common Law ☐Separated ☐Divorced ☐Widowed

Address: _____ City/Town: _____ Prov: _____ Postal Code: _____

Home #: (  ) _____ Mobile #: (  ) _____ Work #: (  ) _____

Email: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Would you prefer to be reminded of your future appointments using-(check **all** that apply): ☐Email ☐Text Message ☐Phone Call

How did you initially learn about Maxwell Dental? _____

Any friends or family you'd like to refer to Maxwell Dental? _____

Have you heard of our annual Halloween Candy Buy-Back? ☐Yes ☐No Have you attended the Halloween Candy Buy-Back? ☐Yes ☐No

**Please Give Your Insurance Card to the Administration**

Primary Insurance Company: _____ Group/Policy #: _____ ID #: _____

Name of Subscriber: _____ Date of Birth of Subscriber: _____ Relationship: ☐Self ☐Spouse☐Child

Secondary Insurance Company: _____ Group/Policy #: _____ ID #: _____

Name of Subscriber: _____ Date of Birth of Subscriber: _____ Relationship: ☐Self ☐Spouse☐Child

# Medical History

*Please answer all of the questions below, honestly. If unsure of a question, please ask the administrator.*

Have you ever been treated for or had/have any of the following (please check **all** that apply):

| | | | | | |
|---|---|---|---|---|---|
| ☐Angina | ☐Cancer | ☐High/Low BP | ☐Hyper Tension | ☐Mental Disorder | ☐STD's, HIV, AIDS |
| ☐Asthma/Hay Fever | ☐Crohn's Disease | ☐Hepatitis A+,B+,B | ☐Hypothermia | ☐Migraines | ☐Sickle Cell |
| ☐Artificial Joints | ☐Dizzy Spells | ☐Heart Lesions | ☐Head/Neck Injury | ☐Organ Transplant | ☐Stroke |
| ☐Arthritis | ☐Diabetes | ☐Heart Disease | ☐Jaundice | ☐Pacemaker | ☐Strep Throat |
| ☐Anemia | ☐Epilepsy | ☐Heart Attack | ☐Kidney Disease | ☐Rheumatic Fever | ☐Tonsillitis |
| ☐Bowel Disease | ☐Emphysema | ☐Heart Valve | ☐Lyme Disease | ☐Radiation/Chemo | ☐Tumor/Growth |
| ☐Blood Disorder | ☐Glandular Disorder | ☐Heart Surgery | ☐Lupus | ☐Scarlet Fever | ☐Thyroid Disease |
| ☐Bronchitis | ☐Glaucoma | ☐Heart Murmur | ☐Lung Disease | ☐Sinus Trouble | ☐Tuberculosis |
| ☐Cortisone/Steroids | ☐Heart Disease | ☐Hodgkin's Disease | ☐Liver Disease | ☐Strep Throat | ☐Ulcers |

☐**None of the above**

Please list **any and all** HEALTH CONDITIONS that have been missed on the above OR ANY ALLERGIES TO ANYTHING:

_____

Are you presently taking any prescription or non-prescription medication including herbal remedies/vitamins/cannabis? ☐Yes ☐No

If yes, please list all: _____

Have you been hospitalize in the past two years? ☐Yes ☐No When was your last visit to a Physician? _____

Have you ever reacted adversely to any medications or injections? ☐Yes ☐No If so, what was it? _____

Have you ever been advised against taking a specific type of medication? ☐Yes ☐No If so, what is it? _____

Have you ever had an operation of any kind, major or minor? ☐Yes ☐No If yes, please list **all** with the approx. dates of when they occurred:

Are you currently being treated for any medical conditions at present or within the past two years? ☐Yes ☐No

How often do you consume alcoholic drinks? ☐Never ☐Occasionally ☐Weekly ☐Daily

Do you smoke or use any other forms of tobacco? ☐Yes ☐No

Do you use recreational or street drugs? ☐Yes ☐No

Do you bleed excessively from a cut or injury? ☐Yes ☐No

Have you ever had a blood transfusion? ☐Yes ☐No

Do you bruise easily? ☐Yes ☐No

Do you have trouble hearing? ☐Yes ☐No

Do you have frequent severe headaches, earaches, ear/throat infections? ☐Yes ☐No

**Female Patients Only:**

Is there a chance you could be pregnant or are pregnant? ☐Yes ☐ No If yes, when is your due date? _____

Are you currently breast feeding: ☐Yes ☐No Are you on any form of birth control: ☐Yes ☐No

**Child Patients Only:**

Has the child recently had any of the following? ☐Mumps ☐Measles ☐Chickenpox

Please indicate when these occurred for the child: _____

# Dental History

*Please answer all of the questions below, honestly. If unsure of a question, please ask the administrator.*

Have you been advised to take antibiotics before dental appointments? ☐Yes ☐No

Is there any dental problem you would like treated immediately? ☐Yes ☐No Explain: _____

Date of your - Last dental visit: _____ Last dental cleaning: _____ Last x-rays: _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you avoid any areas when brushing? ☐Yes ☐No Please explain which area: _____

On a scale of 1-10, how would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Do you have any concerns about having dental treatment or had upsetting or complicated experience in the past? ☐Yes ☐No

If yes, please explain: _____

Are you happy with the appearance of your teeth? ☐Yes ☐No

If no, please explain: _____

**General:**

Have you been seeing a dentist regularly? ☐Yes ☐No

Are you getting Periodontal (gums) treatment? ☐Yes ☐No

Have you ever had any oral surgery? ☐Yes ☐No

Do you feel like you have bad breath? ☐Yes ☐No

Are you being followed up by a dental specialist? ☐Yes ☐No

Are there any abnormal or sore spots in your mouth? ☐Yes ☐No

Do your gums bleed when brushing? ☐Yes ☐No

Have you ever had your bite adjusted/teeth ground? ☐Yes ☐No

Do you have a night guard that you use regularly? ☐Yes ☐No

Have you had Orthodontic(braces) treatment done? ☐Yes ☐No

Have you noticed any loose teeth or shifting? ☐Yes ☐No

Does food catch between your teeth? ☐Yes ☐No

Are any of your teeth sensitive to hot/cold? ☐Yes ☐No

**In association with your jaw:**

Do you suffer from headaches? ☐Yes ☐No

Popping/clicking in your jaw joints? ☐Yes ☐No

Pain in your jaw, ears or the side of your face? ☐Yes ☐No

Difficulty in opening or closing? ☐Yes ☐No

Pain or soreness when chewing? ☐Yes ☐No

**Oral Habits:**

Clench or grind your teeth when awake/asleep? ☐Yes ☐No

Bite your cheeks or lips? ☐Yes ☐No

Place pencils, pins, fingernails, ect. in your mouth? ☐Yes ☐No

Mouth breath while awake/asleep? ☐Yes ☐No

Have you ever been screened for sleep apnea? ☐Yes ☐No

Has someone told you that you gasp for air in your sleep? ☐Yes ☐No

# General Release

*I, the undersigned, certify that I have provided the accurate and complete personal/medical/dental history. I have not knowingly omitted any information. I have had the opportunity to ask questions and received answers to any questions regarding my medical/dental history. Should there be any change in either my health status or personal information I have provided, I will advise this dental office.*

Printed name: _____ Signature: _____ Date: _____

(patient, parent or guardian) (patient, parent or guardian)

**Staff** - Witness Signature: _____