WHITEHILLS DENTAL

Get Acquainted Questionnaire

Full Name: _____ Date of Birth: _____ yy/mm/dd

Home Address: _____

Postal Code: _____ Telephone: ( ) _____

Email Address: _____

Whom may we thank for referring you to our office? _____

Medical History *If you are unsure of any of the following questions, please ask for assistance.*

Name of physician: _____

Are you under the care of a specialist? Yes☐ No☐ Telephone: ( ) _____

Name of specialist: _____ Telephone: ( ) _____

	Yes	No
Have you had a medical examination in the last year?	☐	☐
Have you had a serious illness?	☐	☐
Is your doctor treating you now?	☐	☐
Have you been warned not to take certain medications or food?	☐	☐
Do you have any allergies?	☐	☐
Have you had an unusual reaction to any medication or injection?	☐	☐
Do you have Diabetes?	☐	☐
Do you have high blood pressure?	☐	☐
Have you ever had Rheumatic Fever or Scarlet Fever?	☐	☐
Do you have abnormal bleeding?	☐	☐
Have you had any previous surgery?	☐	☐
Are you taking any prescription or non-prescription medicines regularly?	☐	☐

Please list, indicating purpose and frequency of use: _____

_____

_____

_____

Have you had any ill effects from any of the following? *(please circle)*

Penicillin 292 Aspirin Codeine Advil Barbituates Latex

Others: _____

Is your eyesight: Good Adequate Poor *(please circle)*

Do you wear corrective lenses?	☐	☐
Do you have hearing difficulties?	☐	☐
Have you had any organ transplants, pacemaker or medical artificial implants?	☐	☐
Do you have any condition that could affect your immune system (eg. AIDS, liver disease, HIV positive, Splenectomy, Leukemia, etc.)?	☐	☐
Do you bruise or clot slowly?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Frequency?		

For women only:

Are you pregnant?	☐	☐
If so, what month are you in?		
Do you take birth control pills?	☐	☐

Get Acquainted Questionnaire - cont'd

Have you ever been treated for any of the following?

Chest Pains	☐	Arthritis	☐	Heart Murmur	☐
Stroke	☐	Blood Disorders	☐	Heart Disease	☐
Bronchitis	☐	Dizziness	☐	Diabetes	☐
Asthma	☐	Cancer	☐	Liver Disease	☐
Tuberculosis	☐	Stomach Ulcers	☐	Hepatitis	☐
Drug/Alcohol Addiction	☐	Sinusitis	☐	Epilepsy	☐
Joint Replacement	☐	Ulcers	☐	Herpes	☐
HIV	☐	Thyroid Disease	☐	Venereal Disease	☐
Kidney Disease	☐	Emphysema	☐		

Is there any other medical condition/problem the doctor should be aware of? Yes☐ No☐
Please identify: _____

Personal Data:

Employed by: _____ Occupation: _____
Business Phone: _____ Marital Status: _____
Spouses Name: _____ Employed by: _____
Person responsible for this account: _____
Address if different from above: _____
In case of emergency please call: _____ Telephone:( ) _____
Do you have dental insurance? Yes☐ No☐ Insurance Company Name: _____
Policy/Group Number: _____ Certificate/ID Number: _____
Do you have secondary insurance through your spouse? Yes☐ No☐ Spouse's date of birth: _____ yy/mm/dd
Policy Group Number: _____ Certificate/ID Number: _____
Insurance Company Name: _____

Please Note

Your appointment time is especially reserved for you. If you cannot keep the appointment, we require two business days advance notice. If we are not notified, you will be charged for that lost time. Services are to be paid at each visit as they are performed. In special circumstances, arrangement for payment can be made prior to treatment. Overdue accounts are subject to a 2% service charge (compounded monthly) and accounts beyond 120 days are forwarded to external collections, where all recovery costs to do so will be included in the account.

I, the undersigned, certify that I have provided an accurate and complete health history and have not knowingly omitted any information. I have understood all of the questions asked, and have had the opportunity to ask questions and receive explanations regarding my health history. Should there be any change in my health status in the future, I will advise this dental office. As a new patient to the office, I understand that diagnostic procedures/tests may be necessary to determine treatment, and my verbal consent to the taking of x-rays and the carrying out of other specific diagnostic tests may be required. I further understand that it may be necessary to consult with my physician or another health care professional regarding my current health status, and that my consent to contacting such persons for this purpose will be required. I also understand that responsibility for payment of the dental services for my dependents and myself is mine, and I assume responsibility for fees associated with these services.

Date: _____ Signature: _____

Get Acquainted Questionnaire - cont'd

Full Name: _____ Date of Birth: _____
yy/mm/dd

Dental History:

When was your last dental examination?_____
When was your last full mouth series of x-rays of jaws and teeth?_____
Who was your last dentist?_____
Why did you change dentists?_____
How often do you brush your teeth?_____
What other dental aids do you frequently use?_____ Floss?_____

	Yes	No
Do any medical problems impede your cleaning abilities?	☐	☐
Do your gums bleed with flossing?	☐	☐
Do you presently have any pain in chewing?	☐	☐
Do you have any missing teeth?	☐	☐
If yes, have these teeth been replaced?	☐	☐
Do you notice any clicking or cracking of the jaws in opening?	☐	☐
Have you ever had a tooth extracted?	☐	☐
If yes, were there any complications?	☐	☐
Are you aware of bad breath or tastes in your mouth?	☐	☐
Has any of your previous dental work been done with a local anaesthetic?	☐	☐
Do you bite your cheeks or lips frequently?	☐	☐

Do you smoke?_____ Cigarettes ☐ Pipe ☐ Cigars ☐ Number per day: _____

Are you tense during dental visits?	☐	☐
Are you active in sports?	☐	☐
Do you wear recommended mouth guard protectors?	☐	☐

Are there emotional concerns regarding your dental visit?

Fear ☐ Pain ☐ Embarrassment ☐ Other ☐

Check any of the following that you are interested in:

Orthodontics (Braces)	☐	Improving gum health	☐
Bonding (Esthetic Straightening)	☐	Improving breath	☐
Replacing missing teeth	☐	Crowns (Caps)	☐
Whitening teeth	☐	Sports Mouth Guard	☐
Improving bite and smile	☐	Implants	☐

If you could change the appearance of your teeth in any way, what would you change?

_____
_____
_____
_____

Thank You!

Date:_____ Signature:_____