7TH STREET
DENTAL CENTRE

Welcome to our Practice

Confidential Patient Questionnaire

Please fax back to 780-425-9668 or email to reception@seventhstreetdental.ca

Personal Information

Title: ○ Mr. ○ Mrs. ○ Ms. ○ Dr. ○ Other_____ Today's Date: _____
day month year

Surname: _____ First Name: _____

Date of Birth: _____ Height:_____ Weight: _____ Occupation:_____
day month year

Home Address: _____ City: _____ Postal Code:_____

Phone: Home ( ) _____ Work: ( )_____ Cell: ( ) _____

E-Mail: _____

Personal Physician(s):_____ Phone: ( )_____

In case of Emergency notify: Name:_____ Relationship: _____ Phone: ( ) _____

Previous Dentist:_____Phone: ( )_____ Date of last visit: _____
day month year

May we request previous records? ○ Yes ○ No

Who may we thank for referring you? _____

Medical History

1. Are you presently receiving medical care? For: _____ ○ Yes ○ No
2. Have you had any serious illness or operation/or have you ever been hospitalized? ○ Yes ○ No

   Illness: _____

   Operations: _____
3. Are you taking any drugs or medicine (prescription or non prescription)? ○ Yes ○ No

   If so, what (dosages)? _____

   _____

   _____

   Which drugs have you had in the past? _____

   _____
4. Are you allergic to (or have reacted adversely) any drug, medicine, or OTHER substance?
   eg. local anaesthetic (freezing), general anaesthetic, Penicillin or other antibiotics, barbiturates, sedatives, analgesics (painkillers)? _____ ○ Yes ○ No
5. Do you have any allergies? ○ Yes ○ No If so, to what? _____

Continued on the reverse side...

6. Do you have (or have you had) any of the following conditions or problems? (Check any that apply):

○ Rheumatic Fever	○ Asthma/Breathing Disorder	○ Thyroid Disease
○ Rheumatic Heart Disease	○ Skin Rash	○ Kidney Disease/Disorder
○ Heart Murmur	○ Lung Disorder	○ Alcoholism/Substance Abuse
○ Congenital Heart Lesions	○ Tuberculosis	○ Jaundice/Liver Disease
○ Heart Trouble	○ Fainting Spells	○ Joint Replacement
○ Heart Attack	○ Nervous Disorder	○ Gastrointestinal Disease
○ Heart Surgery	○ Seizures (eg: Epilepsy)	○ Bone, Muscle or Joint Disorder
○ Arteriosclerosis	○ Pregnancy	○ Bruising
○ Stroke	○ Sensitivity to Metals	○ High Blood Pressure
○ Anemia	○ Hay Fever	○ Bleeding/Blood Disorder
○ Radiation Treatment	○ Allergy to Latex	○ Cosmetic Surgery
○ Chest Pains	○ Diabetes	○ Delayed Healing
○ Shortness of Breath	○ Endocrine Disorder	○ Chronic Disease/Condition
○ Hepatitis A/B/C	○ STI	○ Other:_____

7. Have you gained or lost excessive weight recently? ○ Yes ○ No If so, how much: _____

8. To the best of your knowledge, have you come in contact with A.I.D.S. or H.I.V. ○ Yes ○ No

9. Do you have unhealed injuries or inflamed areas, growths, sore spots in or around your mouth? ○ Yes ○ No

10. Is there any history of family disease? ○ Yes ○ No

11. Are you on a special diet? ○ Yes ○ No

12. Are you currently in good health? ○ Yes ○ No

13. Do you smoke? ○ Yes ○ No If so, how much/day? _____ Do you use smokeless tobacco? ○ Yes ○ No

14. What is the reason for today's visit? _____

15. On a scale of 1 to 4, (1 being calm-4 being very afraid) how comfortable are you receiving dental treatment?

calm 1 2 3 4 very afraid

The above represents a current and accurate health history and personal information. I hereby consent to examination, necessary tests or records, photographs, medication, local anesthesia, sedation and recommended treatment as explained by the Doctor which includes explanation of the feasible treatment alternatives. I further consent to the taking of photographs, or other tests showing the condition of my mouth or my treatments for the purpose of documentation, my education, or for dental, scientific and educational purposes. I understand and agree that payment of professional services is due and payable at the time of service. I am responsible for any additional collection costs incurred.

Date _____ Signature: _____

OFFICE USE ONLY:

Baseline BP _____ Baseline HR _____ Baseline O_2 _____