Morgan Creek Dental Clinic

Your Friendly Professional Dental Care Provider

In an effort to serve you better, we would ask you complete the following. We will be glad to assist you. PLEASE PRINT

PATIENT INFORMATION A parent of guardian will be responsible for decisions on any treatment ☐ YES ☐ NO

First Name: ________________ Last Name: ________________ Preferred Name: ________________

Date of Birth: ____________________ (DD/MM/YY) Gender ____________________

Address: ____

Street Apt/Unit # City Province Postal Code

Home Number: ______________ Work Number: ______________ Mobile Number: ______________

Email address: ____

Emergency Contact: ________________________ Tel: ________________________

Family Doctor: ________________________ Tel: ________________________

FINANCIAL INFORMATION Method of payment Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐

Person responsible for financial matter: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

First Name: ________________ Last Name: ________________ Preferred Name: ________________

Address: ____

Street Apt/Unit # City Province Postal Code

Date of Birth______________ (DD/MM/YY) Home Number: ______________ Mobile Number: ______________

INSURANCE INFORMATION

1. Name of primary Insurance Policy Holder: ________________ Date of Birth: __________ (DD/MM/YY)

Relation to Policy Holder: ________________ Insurance Company Name: ________________

Group Policy/Plan Number: _______ I.D./Certificate Number: ______________

2. Name of secondary Insurance Policy Holder: ________________ Date of Birth: __________ (DD/MM/YY)

Relation to Insurance Policy Holder: ________________ Insurance Company Name: ________________

Group Policy/Plan Number: _______ I.D./Certificate Number: ______________

DENTAL HISTORY

1. What is the reason of today's visit? ☐ Emergency ☐ Examination ☐ Other ______________
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Others ______________
3. When was your last dental visit? ______________ last X-rays ______________
4. How often do you brush per day? __________ floss? __________ use of mouth rinse? __________
5. Are your teeth sensitive to: ☐ cold ☐ sweet ☐ heat ☐ other ______________?
6. Do your gums bleed when: ☐ brushing ☐ flossing ☐ Never

	YES	NO
7. Do your gums feel swollen or tender? ______________	☐	☐
8. Do you have bad breath or a bad taste in your mouth? ______________	☐	☐
9. Do your jaws crack, pop or grate when you open widely? ______________	☐	☐
10. Do you grind or clench your teeth? ______________	☐	☐
11. Do you have food catch between your teeth? ______________	☐	☐
12. Have you ever had local anaesthetic (freezing)? Any complication? ☐ YES ☐ NO Specify ______________	☐	☐
13. Have you ever had any problem with previous treatments? specify ______________	☐	☐
14. Have you ever had any of the following: ☐ Bridgework ☐ Crown or Caps ☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gums) ☐ Root Canals		
15. Are you satisfied with your teeth? Specify ______________	☐	☐

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MEDICAL HISTORY (This information will remain confidential) YES NO

1. Are you presently under the care of physician: If so, please explain? ________________________________ ___ ___
2. Have you ever been hospitalized? Explain____ ___ ___
3. Are you taking any drugs or medication currently?
   - ☐ Drug ____________________ Reason ____________________
   - ☐ Drug ____________________ Reason ____________________
   - ☐ Drug ____________________ Reason ____________________
4. Do you have any of the following allergies? ☐Penicillin ☐ Aspirin ☐ Codeine ☐Latex ☐Local anaesthesia ☐ Percocet
   ☐ Sulpha ☐ Erythromycin ☐Codeine ☐Barbiturates (sleeping pills) ☐Darvon ☐Other_________________________
5. Have you ever been warned against using any other medication? Which? ____________________________ ___ ___
6. Have you ever taken prolonged medical or non-medical drugs? Which? ______________________________ ___ ___
7. Do you suffer from any allergies (hay fever, latex etc.?) Which? __________________________________ ___ ___
8. Do you bruise easily or have prolonged bleeding?____ ___ ___
9. Do you smoke cigarette, e-cigarette, or use recreational drugs (e.g. Marijuana)? How much per day? _______ ___ ___
10. Have you ever fainted, had shortness of breath or chest pains? ____________________________________ ___ ___
11. Do you have or ever had a replacement or repair of a heart valve, infection of the heart (infective endocarditis), a heart condition from birth (congenital heart disease) or a heart transplant? ____________________________ ___ ___
12. WOMEN Are you pregnant? Yes☐ No☐ Using birth control? Yes☐ No☐ Reached menopause? Yes ☐ No☐
13. Please check any of the following that apply to you: ☐ NONE

☐ AIDS/ HIV positive	☐ Diabetes	☐ Drug/alcohol dependence	☐ Radiation (head/neck)
☐ Asthma	☐ Dizziness	☐ Hodgkin disease	☐ Respiratory problems
☐ Angina pectoris	☐ Epilepsy	☐ High/Low blood pressure	☐ Rheumatic/Scarlet fever
☐ Anorexia nervosa	☐ Emphysema	☐ HPV	☐ Sickle Cell disease
☐ Anemia	☐ Excessive bleeding	☐ Hypertension	☐ Sinus/intestinal problems
☐ Arthritis/rheumatism	☐ Glandular disorders	☐ Jaundice	☐ Seizures
☐ Artificial heart valve	☐ Glaucoma	☐ Jaw joint pain	☐ Sleep apnea
☐ Artificial joints	☐ Head/ Neck injuries	☐ Kidney disease	☐ Stomach problems
☐ Bulimia	☐ Heart disease/ attack	☐ Leukemia	☐ Stroke
☐ Blood disease	☐ Hepatitis A/B/C	☐ Liver disease	☐ Thyroid disease
☐ Bronchitis	☐ Heart murmur	☐ Lung disease	☐ Tuberculosis
☐ Cancer	☐ Heart pacemaker/ surgery	☐ Mitral valves prolapse	☐ Ulcers
☐ Circulation problems	☐ Heart rhythm disorder	☐ Malignant hyperthermia	☐ Venereal diseases
☐ Cortisone/Steroid	☐ Heart lesions, congenital	☐ Mental/nervous disorders	☐ Other___________
☐ Chemotherapy	☐ Herpes	☐ Organ transplant/implant	☐ Other___________
☐ Congenital heart lesions	☐ Hyper/Hypo Glycemia	☐ Psychiatric disorders	☐ Other___________

13.CHILDREN have you recently had any of the following (approximate date)?

☐ Chicken pox ☐Measles ☐ Mumps ☐ Strep Throat ☐ Tonsillitis ☐ NONE

GENERAL RELEASE: I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted date. I consent to the release of medical information from my medical doctor or other health care as is requited by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

____

Signature ☐patient ☐parent/ guardian Print name Date