WELCOME TO OUR PRACTICE

NEW PATIENT INFORMATION FORM

PORT
DENTAL HEALTH
& IMPLANT CENTRE

First Name: _____ Last Name: _____

Date of Birth: _____ Marital Status: _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

How do you prefer to be contacted? ☐ Cell ☐ Home Phone ☐ Email ☐ Work Phone:

Who do we call in case of emergency? Name: _____ Phone: _____

Who can we thank for referring you (how did you find out about our practice)?:

☐ Patient: _____ (Relationship) _____ ☐ Website

☐ Online / Google Search ☐ News Paper Ad ☐ Walk by ☐ External Signage

☐ Social Media

Personal History

It is important to us that we meet your needs and address your primary concerns therefore we ask you to share the following information leading into your appointment today:

What is your primary concern today: _____

When did this become a concern: _____

How would you describe your last dental experience: _____

What prevented you from returning to your former Dentist?: _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Do you have or have you ever hadever have Braces, Orthodontics, Treatment or Upper Bite Adjustment?: ☐ Yes ☐ No

3633 3rd Avenue
Port Alberni, BC
V9Y 4E7

Phone: 250-724-6527
Email: portdental@shaw.ca
www.portdental.com

DENTAL HISTORY

Please answer Yes or No to the following:	YES	NO
Gum and Bone		
Do your gums bleed or are they painful when brushing or flossing?	☐	☐
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
Is there anyone with a history of periodontal disease in your family?	☐	☐
Have you ever experienced gum recession?	☐	☐
Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
Tooth Structure		
Have you had any cavities within the past 3 years?	☐	☐
Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
Do you frequently get food caught between any teeth?	☐	☐
Smile Characteristics		
33. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Your Privacy is Always Assured

Privacy of our patient's personal information is important to us. Personal information is necessary for providing professional oral health care services to you and information necessary to administer your dental treatment.

I authorize communication of this personal information by mail, electronic and verbal means. Personal information includes clinical records, X-rays, study models, photographs of you and your teeth, mouth, smile and face, and general health information obtained from a medical history review, insurance information, phone numbers and email addresses. Clinical information and photographs, x-rays may also be used for long-term follow-up and research purposes, as well as for education or teaching purposes.

Your personal information will only be shared with those who have a need to know and specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include referring dentists, other dental specialists, physician(s), dental laboratories and insurance carriers.

I certify that I have read and understand this document.

Signature/Parent or Guardian: _____ Date: _____

Signature/Parent or Guardian: _____ Date: _____

MEDICAL HISTORY

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been instructed to take pre-medication prior to dental treatment? _____

Do You Have or Have You Ever Had:	YES	NO
1. hospitalization for illness or injury	☐	☐
2. an allergic reaction to:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfalocal		
☐ anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) ____	☐	☐
6. pacemaker or implantable defibrillator_____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners)_____	☐	☐
11. anemia or other blood disorder_____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems_____ (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice_____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders _____ (i.e. celiac disease, gastric reflux)	☐	☐
26. osteoporosis/osteopenia _____ (i.e. taking bisphosphonates)	☐	☐
27. arthritis_____	☐	☐
28. autoimmune disease_____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____		
30. contact lenses_____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders _____ (ADD/ADHD, prion disease)	☐	☐
34. viral infections and cold sores _____		
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type _____) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. biphosphonates _____	☐	☐
43. chemotherapy, immunosuppressive medication___	☐	☐

	YES	NO
44. emotional difficulties	☐	☐
45. psychiatric treatment	☐	☐
46. antidepressant medication	☐	☐
47. alcohol / recreational drug use	☐	☐

Are You:

48. presently being treated for any other illness	☐	☐
49. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches	☐	☐
53. a smoker, smoked previously or use smokeless tobacco	☐	☐
54. taking birth control pills	☐	☐

	YES	NO
55. currently pregnant	☐	☐
56. prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections).

List all medications, supplements, and or vitamins taken within the last two years.

Please advise us in the future of any change in your medical history or any medications you may be taking.

Drug	Purpose	Drug	Purpose

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

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