# Woodbridge / Vaughan Periodontic & Implants

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Last Name ______ Address ______
First Name ______ City ______
Initial ______ Province ______ Postal Code ______
Home Phone ______ Cell Phone ______ Email ______

Check an appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent/Guardian's Employer ______ Work Phone ______
Business Address ______ City ______ Province ______ Postal Code ______
Spouce or Parent/Guardian Name ______ Employer ______ Work Phone ______
If Patient is a Student, Name of School ______ City ______ Province ______
Whom May We Thank For Referring You? ______
Person to Contact in Case of Emergency ______ Phone ______

## RESPONSIBLE PARTIES

Name of Person Responsible for This Account ______ Relationship to Patitent ______
Address ______ Home Phone ______
Email ______ Work Phone ______
Driver's Lic. # ______ Birthdate ______ Financial Institution ______
Employer ______ Work Phone ______
Is this person currently a patient in our office? ◯ Yes ◯ No

## INSURANCE INFORMATION

Name of Insured ______ Birthdate ______ SIN # ______ Relation to Patient ______
Name of Employer ______ Date of Employment ______ Work Phone ______
Address of Employer ______ City ______ Province ______ Postal Code ______
Insurance Company ______ Group # ______ Union/Local # ______
Ins. Co. Address ______ City ______ Province ______ Postal Code ______
How Much is Your Deductible? ______ How Much Have You Used? ______ Max. Annual Benefit ______

# PATIENT MEDICAL HISTORY

Physician [ ] Office Phone [ ] Date of Last Exam [ ]

| | YES | NO |
|---|---|---|
| Are you under medical treatment now? | ☐ | ☐ |
| Have you ever been hospitalized for any surgical operation or serious illness? | ☐ | ☐ |
| Are you taking any medication(s) including non-prescription? If yes, what? [ ] | ☐ | ☐ |
| Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| Do you use tobacco? | ☐ | ☐ |
| Do you use alcohol, cocaine, or other drugs? | ☐ | ☐ |
| Are you wearing contact lenses? | ☐ | ☐ |

Are you allergic to or have you had any reactions to the following?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Local Anesthetics (e.g. Novocaine) | ☐ | ☐ | Barbiturates | ☐ | ☐ | Aspirin |
| ☐ | ☐ | Penicillin or other Antibiotics | ☐ | ☐ | Sedatives | ☐ | ☐ | Other [ ] |
| ☐ | ☐ | Sulfa Drugs | ☐ | ☐ | Iodine | | | |

| | YES | NO |
|---|---|---|
| Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | ☐ | ☐ |
| Women Only: | | |
| - Are you or do you think you may be pregnant? | ☐ | ☐ |
| - Are you nursing? | ☐ | ☐ |
| - Are you taking birth control medication? | ☐ | ☐ |

Do you have or have had any of the following?

| YES | NO | | YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Cancer | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Heart Attack | ☐ | ☐ | AIDS or HIV | ☐ | ☐ | Arthritis | ☐ | ☐ | Radiation Therapy |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Thyroid Problem | ☐ | ☐ | Joint Replacement/Implant | ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Swollen Ankles | ☐ | ☐ | Heart Disease | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Recent Weight Loss |
| ☐ | ☐ | Fainting / Seizure | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Sexually Transmitted Diseases | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Asthma | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ | Heart Trouble |
| ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Angina | ☐ | ☐ | Chest Pain | ☐ | ☐ | Respiratory Problems |
| ☐ | ☐ | Epilepsy / Convulsions | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Easily Winded | ☐ | ☐ | Other: [ ] |
| ☐ | ☐ | Leukemia | ☐ | ☐ | Anemia | ☐ | ☐ | Stroke | | | |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Emphysema | ☐ | ☐ | Hay Fever / Allergies | | | |

# PATIENT DENTAL HISTORY

| | YES | NO |
|---|---|---|
| Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| Are your teeth sensitive to hot / cold liquids/foods? | ☐ | ☐ |
| Are your teeth sensitive to sweet / sour liquids/foods? | ☐ | ☐ |
| Do you feel pain to any of your teeth? | ☐ | ☐ |
| Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| Have you had any head, neck, or jaw injuries? | ☐ | ☐ |
| Have you ever experienced any of the following problems in your jaw? | | |
| - Clicking | ☐ | ☐ |
| - Pain (joint, ear, side of face) | ☐ | ☐ |
| - Difficulty in opening / closing | ☐ | ☐ |
| - Difficulty in chewing | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Do you have frequent headaches? | ☐ | ☐ |
| Do you clench or grind your teeth? | ☐ | ☐ |
| Do you bite your lips / cheeks frequently? | ☐ | ☐ |
| Have you had any difficult extractions in the past? | ☐ | ☐ |
| Have you had any orthodontic work? | ☐ | ☐ |
| Have you ever had prolonged bleeding after extraction? | ☐ | ☐ |
| Have you ever had instruction on the correct method of brushing your teeth? | ☐ | ☐ |
| Have you ever had instructions on the care of your gums? | ☐ | ☐ |

**NOTE: If you choose to email this form directly to our office, you will be asked to sign here during your first office visit.**

X ______________________________

Signature of Patient or Parent/Guardian if Minor