mccabe
FAMILY DENTISTRY

NEW PATIENT FORM

Patient name _____ _____ _____

Surname Given Names Preferred name

Address _____

Phone number _____ _____ _____

Home Cell Work

E-mail _____

Preferred contact method: □ Phone □ E-mail □ Text Message

DENTAL INSURANCE INFORMATION

Please complete this section if you have coverage under a dental insurance plan

Primary Insurance Plan

Company:

_____

Plan Number:

_____

Subscriber ID Number:

_____

Secondary Insurance Plan (if applicable)

Company:

_____

Plan Number:

_____

Subscriber ID Number:

_____

MEDICAL HISTORY

In case of emergency, whom should we contact? Please include name, their relationship to you, and the best phone number to contact them.

_____

Please provide the name and contact information for your medical doctor(s) – general practitioners and specialists

_____

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When was your last medical check-up? _____

What pharmacy do you generally use? _____

Please provide your OHIP number _____

Are you being treated for any medical condition at present or within the past year?

_____

Have there been any changes to your general health in the past year? Any hospitalizations in the past 5 years?

_____

_____

Are you taking any medications, non-prescription drugs, inhalers, or herbal supplements of any kind?

_____

_____

_____

Do you have any allergies or adverse reactions to any medications, materials, or foods?

_____

_____

Do you or have you ever smoked or chewed tobacco products? How much and how often? Have you tried to quit or are you interested in quitting?

_____

Do you have, or have you ever had cancer? Did you undergo chemotherapy or radiation to the head and neck region?

_____

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Do you have, or have you ever had any of the following?

□ ADD/ADHD
□ Antibiotics prior to dental visits
□ Arthritis
□ Asthma or shortness of breath
□ Autism
□ Bacterial Endocarditis
□ Cancer
□ Congenital heart failure
□ Depression/anxiety
□ Diabetes
□ Drug/alcohol dependency
□ Epilepsy/seizures
□ Gastroesophageal reflux (GERD/acid reflux)
□ Heart attack
□ Heart Murmur
□ Heart Valve Concerns
□ Heart Valve Replacement
□ Hepatitis or Liver disease
□ HIV/AIDS
□ Hypertension (high blood pressure),
□ Kidney disease
□ Leukemia
□ Lung Disease
□ Organ Transplant
□ Osteoporosis medications (Fosamax, Actonel, etc.)
□ Pacemaker
□ Radiation therapy
□ Rheumatic Fever
□ Sinus Issues
□ Sleep Apnea/snoring/use of CPAP
□ Steroid Therapy
□ Stomach Ulcers
□ Stroke
□ Tuberculosis
□ Thyroid Disease

Women Only: Are you pregnant ? When is your expected delivery date?

_____

Women only: Are you breastfeeding?

_____

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DENTAL HISTORY

What brings you to our office? Do you have any immediate dental concerns?

_____

When was your last dental visit and what was done? When were your most recent dental radiographs (x-rays) taken?

_____

I routinely saw my dentist every

□ 3 months □ 6 months □ 9 months □ 12 months □ Not routinely

How nervous are you about dental treatment on a scale of 1 (low) to 10 (high)? _____

Have you ever had an unfavorable dental experience or complications as a result of dental treatment? Please explain:

_____

Please indicate any concerns or conditions that apply to you:

□ Bleeding Gums

□ Bruxism (clenching and grinding)

□ Difficulty with freezing

□ Dry Mouth

□ Gag Reflex

□ Gum Recession

□ Jaw Joint Concerns (TMJ/TMD)

□ Nail Biting or other habits

□ Orthodontics

□ Periodontal disease (gum disease)

□ Sensitivity

□ Teeth shifting position

What, if anything, would you change about your smile?

_____

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Patient Release

I, the undersigned, certify that I have provided an accurate and complete medical and dental history and have not knowingly omitted any information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care

Signature _____ Date _____