Hilltop DENTISTRY
519-376-5225
www.hilltopdentistry.ca

Welcome to Our Office

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

Patient Information

A parent or guardian will be responsible for decisions on my treatment ☐Yes ☐No

Name: _____
First *Initial* *Last*

Address: _____
Street *Apt.*

_____
City *Prov.* *Postal Code*

Date of Birth: ___/___/___ (D M Y) Home Tel. (___) _____ Work Tel. (_____) _____

Emergency Contact: _____ Tel. (_____) _____

Family Doctor: _____ Tel. (_____) _____

Referring Doctor: _____ Tel. (_____) _____

Whom may we thank for referring you? _____

Financial Information

Method of Payment: Cash☐ Cheque☐ Credit Card☐ Insurance☐ Other☐

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

If Different than Above:

Name: _____
First *Initial* *Last*

Address: _____
Street *Apt.*

_____
City *Prov.* *Postal Code*

Date of Birth: ___/___/___ (D M Y) Home Tel. (____) _____ Work Tel. (____) _____

Insurance

Insurance Company: _____ Tel. (_____) _____

Employer/Policy Holder _____ Ins. Yr. End: _____

Policy# _____ Certificate# _____ ID# _____

Max Cov. _____ %coverage for ____ Basic ____Maj. Restorative ____Orthodontic

Dental History

1.What is the reason for today's visit? ☐Emergency ☐Examination ☐Other

2. How frequently do you see a dentist? ☐3-6 months ☐Annually ☐Other

3. When was your last dental visit?_____ Last X-Ray?_____

4. How often do you brush per day?_____ Floss?_____ Use Anti-bacterial rince?_____

5. Are your teeth sensitive to: ☐Cold ☐Sweets ☐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 complications? ☐Yes ☐No ☐Specify _____		
13. Have you ever had any problem with previous dental treatments?	☐	☐
Specify _____		
14. Have you ever had any of the following: ☐Bridgework ☐Crowns or Caps ☐Full or Partial Dentures ☐Orthodontic (braces) ☐Peridontal (Gums) ☐Root Canal		
15. Are you satisfied with your teeth? Specify _____	☐	☐

Medical History *(This information will remail confidential)* Date: _____ **YES** **NO**

1. Are you presently under the care of a physician? if so, explain. _____ ☐ ☐
2. Have you ever been hospitalized? ☐ ☐
   Explain _____
3. Are you taking any drugs or medications at this time? ☐ ☐
   A) Drug _____ Reason _____
   B) Drug _____ Reason _____
   C) Drug _____ Reason _____
4. Have you ever had any adverse effects to any of the following:
   Antibiotic-Penicillin Sulfonamide Other
   Asprin Barbiturates (sleeping pills) Codeine
   Darvon Local Anaesthetic NONE
5. Have you ever been warned against using any other medications? ☐ ☐
   Which? _____
6. Have you ever taken prolonged medical or non-medical drugs? ☐ ☐
   Which? _____
7. Do you suffer from allergies (hay fever, latex, etc.)? ☐ ☐
   Which? _____
8. Do you bruise easily or have prolonged bleeding? ☐ ☐
9. Do you smoke? How much per day? ☐ ☐
10. Have you ever fainted, had shortness of breath or chest pains? ☐ ☐
11. WOMEN: Are you pregnant? ☐ Yes ☐ No
    Using Birth Control ☐ Yes ☐ No
    Reached menopause? ☐ Yes ☐ No
12. Do you have or have you ever had any of the following? Please ✓ appropriate boxes. ☐ NONE

☐ A.I.D.S	☐ Epilepsy or seizures	☐ Lung disease
☐ Anemia	☐ Glandular disorders	☐ Malignant hyperthermia
☐ Angina pectoris	☐ Glaucoma	☐ Mental/nervous disorder
☐ Anorexia nervosa	☐ Head/Neck injuries	☐ Mitral valve prolapse
☐ Arthritis/rheumatism	☐ Heart disease/attack	☐ Organ transplant/implant
☐ Artificial heart valve	☐ Heart murmur	☐ Psychiatric treatment
☐ Artificial joints (hip, knee)	☐ Heart pacemaker/surgery	☐ Lung disease
☐ Asthma	☐ Heart rhythm disorder	☐ Radiation/Chemotherapy
☐ Blood disorders	☐ Hepatitis A, B, C	☐ Rheumatic/Scarlet fever
☐ Bronchitis	☐ Herpes	☐ Sickle Cell disease
☐ Bulimia	☐ High/Low blood pressure	☐ Sinus trouble
☐ Cancer	☐ H.I.V. Positive	☐ Stomach/instestinal problems
☐ Circulation problems	☐ Hodgkins disease	☐ Stroke
☐ Congenital heart lesions	☐ Hyper (Hypo) Glycemia	☐ Thyroid disease
☐ Cortisone/steroid	☐ Hypertension	☐ Tuberculosis
☐ Diabetes	☐ Jaundice	☐ Ulcers
☐ Drug/Alcohol dependence	☐ Kidney disease	☐ Venereal disease
☐ Emphysema	☐ Liver Disease	☐ 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 the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required 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.

Thank you!

_____ _____ _____

Signature ☐ Self ☐ Parent/Guardian Print name Date