"Patient Centered Care"

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Full name _____Prefer to be called_____

Birth date _____ Name of spouse _____ Name of parent (under 18)_____
D/M/Y

Home phone _____ Fax _____ E-mail_____ May we contact you at home?_____

Home address _____ City _____ Province _____Code_____

Employed by _____ Phone _____ Fax _____E-mail_____

Spouse employed by _____ Phone _____ Fax _____E-mail_____

May we contact you or your spouse at work?_____ Are you available for appointments on short notice? _____

Who will pay for this account? _____ Address/phone_____

Do you have dental insurance? _____ Does your spouse have dental insurance? _____

1' subscriber _____Company _____Plan number_____Subscriber ID_____

2' subscriber_____ Company_____Plan number_____Subscriber ID_____

Referred by_____

It is important that I know about your dental and medical history. Many things have a direct bearing on your health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

DENTAL HISTORY

How can we help you? _____

Previous dentist_____ Address _____

Date of last dental appointment _____ What was done at this appointment?_____

Usual frequency of dental visits _____ Date of most recent x-rays_____

Do you like the way your teeth feel and look?_____

What would you like to see changed?_____

Have you ever had any teeth removed? _____Were they ever replaced?_____

Are your teeth sensitive to hot, cold, sweets, or biting? _____

Does food get trapped between your teeth when you chew? _____

Do you clench or grind your teeth during the day or night? _____

Have you ever had a bite plate or any other appliance? _____

How often do you brush your teeth? _____How often do you use dental floss?_____

When was the last time that you had your teeth cleaned professionally? _____

Are your gums tender, irritated or swollen? _____Do they bleed when you brush or floss?_____

Do you have any teeth which feel loose? _____

Do you smoke? _____How often?_____

Have you ever had periodontal (gum) treatment? _____

Have you had any previous problems with dental treatment? _____

Are you fearful or apprehensive about dental care? _____