Brookfield Dentistry s.c.

Information (Confidential)

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opeining or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Have you ever had periodontal treatment?	☐	☐
15. Were you ever referred to a periodontist for any treatment?	☐	☐
16. Do you wear dentures or partials?	☐	☐
If yes, date of placement		
17. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
18. Do you like your smile?	☐	☐

Patient's Signature	Date	Staff Member's Signature	Date
Patient's Signature	Date	Staff Member's Signature	Date
Patient's Signature	Date	Staff Member's Signature	Date
Patient's Signature	Date	Staff Member's Signature	Date
Patient's Signature	Date	Staff Member's Signature	Date
Patient's Signature	Date	Staff Member's Signature	Date

Name _____

Medical Questionnaire

Name of Physician _____ Phone # _____

History of hospitalizations or illnesses in the last 5 years _____
(including cancer treatment) _____

HAVE YOU EVER HAD OR HAVE YOU NOW: *(Please check at the Right of each item)*

(Check each item)	YES	NO	DON'T KNOW		YES	NO	DON'T KNOW		YES	NO	DON'T KNOW
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or Dizziness				Bruise or Bleed Easily				Kidney Problems			
Nervous Disorder/Psychiatric Care				Heart Problems or Angina				Sexually Transmitted Disease			
Stroke				High Blood Pressure				Diabetes			
Glaucoma				Rheumatic Fever				Thyroid Disease			
Cold Sores (Herpes)				Heart Murmur				HIV + / AIDS			
Persistent Cough				Mitral Valve Prolapse				Arthritis			
Emphysema				Congenital Heart Lesions				Painful Joints (including jaw)			
Tuberculosis / PPD Positive				Heart Surgery				Artificial Joints			
Asthma				Prosthetic Heart Valve				Hives			
Hay Fever				Pacemaker				Steroid Medication(s)			
Sinus Problems				Blood Transfusion(s)				Drug Addiction			
Anemia				Liver Disease				Alcoholism			
Sickle Cell Disease				Yellow Jaundice				Unexplained Weight Change			
G-6PD Deficiency				Hepatitis - Type:				Cancer / Radiation			
High Cholesterol				History of Infective Endocarditis				Alcohol or Drug Abuse			

Medications

_____
_____
_____
_____
_____

Over the counter or herbal medications:

_____
_____
_____
_____
_____

Allergies

Are you allergic to or have you had any allergic reaction to the following:

Local Anesthetics (e.g. Novacain)	Y ☐ N ☐	Iodine	Y ☐ N ☐
Penicillin or any other Antibiotics	Y ☐ N ☐	Aspirin	Y ☐ N ☐
Any Metals (e.g. nickel, mercury, etc.)	Y ☐ N ☐	Sulfa Drugs	Y ☐ N ☐
Barbiturates	Y ☐ N ☐	Latex Rubber	Y ☐ N ☐
Sedatives	Y ☐ N ☐	Other _____	Y ☐ N ☐

Do you use tobacco? _____

If yes, type & frequency _____

Do you use alcohol? _____ How often? _____

Do you drink soda or sports drinks? _____ How often? _____

1. Have you ever taken Fosamax, Aredia, Zometa, or any other Bisphonate drugs either by mouth or intravenously? Y ☐ N ☐ Don't Know ☐
2. Have you ever been told that you should not donate blood? _____ Y ☐ N ☐ Don't Know ☐
3. Have you ever been told that you need antibiotics before dental treatment? _____ Y ☐ N ☐ Don't Know ☐
4. Females: Are you taking birth control pills (BCPs)? _____ Y ☐ N ☐ Don't Know ☐
   Are you or might you be pregnant? (Estimated delivery) _____ Y ☐ N ☐ Don't Know ☐
   Are you breast feeding at the present time? _____ Y ☐ N ☐ Don't Know ☐
5. Do you have a disease, condition, or problem not listed above? _____ Y ☐ N ☐ Don't Know ☐
   If yes, please describe: _____