cmdc
churchill meadows dental centre

Welcome to Churchill Meadows Dental Centre

WHOM SHOULD WE THANK FOR REFERRING YOU TO OUR OFFICE ?

Another patient ______________________ Live in Area Location Newsletter School Magnet Internet Yellow Pages

A parent or guardian will be responsible for decisions on my treatment: Ye s No

Patient Information

Name: ____
First Last Middle Initial Preferred

Phone #: ____________________________________ **Email:** ____________________
Home Work Cell / Other

Address (Home): ____
Street Apt. City Prov Postal Code

Address (Work): ____
Street Suite City Prov Postal Code

Date of Birth: ______________________ Employer: ____________________ Occupation: ____________________
Day Month Year

In case of **EMERGENCY**, we should contact: ____
Name Relationship Phone#

Family Doctor: ______________________________ Tel: ______________________________

Previous Dentist: ______________________________ Tel: ______________________________

Financial Information

Method of Payment: Cash Interac Mastercard Visa Amex

Person responsible for financial matters: Self Spouse Parent/Guardian

IF DIFFERENT FROM ABOVE

Name: ____
First Initial Last

Address: ____
Street Apt. City Prov. Postal Code

Date of Birth: ______________________ Phone #: ______________________________
Month Day Year Home Work

1° INS INFO

Ins. Company: ______________________________ **RECARE FREQUENCY:** **6 Month** **9 Month**

Employer: ______________________ Policy #: ______________ Certificate / I.D. #: ______________

2° INS INFO

Ins. Company: ______________________________ **RECARE FREQUENCY:** **6 Month** **9 Month**

Employer: ______________________ Policy #: ______________ Certificate / I.D. #: ______________

(Please continue on to Medical and Dental History – Thank you)

The following information will help enable us to provide you with the best possible dental care. All information is strictly private, and is protected by dentist-patient confidentiality. Dr. Patel will review the questions and explain any that you do not understand. Please fill in the entire form. Thank you.

Medical History

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
   YES NO NOT SURE
2. When was your last medical checkup?
3. Has there been any change in your general health in the past year? If yes, please explain.
   YES NO NOT SURE
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
   YES NO NOT SURE
5. Do you have any allergies? If you answered yes, please list using the categories below:
   a) Medications
   b) Latex / rubber products
   c) Other e.g. hay fever, foods
   YES NO NOT SURE
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
   YES NO NOT SURE
7. Do you or have you ever had asthma?
   YES NO NOT SURE
8. Do you have or have you ever had any heart or blood pressure problems?
   YES NO NOT SURE
9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
   YES NO NOT SURE
10. Do you have a prosthetic or artificial joint?
   YES NO NOT SURE
11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
   YES NO NOT SURE
12. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
   YES NO NOT SURE
13. Have you ever had hepatitis, jaundice or liver disease?
   YES NO NOT SURE
14. Do you have a bleeding problem or bleeding disorder?
   YES NO NOT SURE
15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
   YES NO NOT SURE
16. Do you have or have you ever had any of the following? Please check.

chest pain, angina	shortness of breath	pacemaker	steroid therapy	seizures (epilepsy)	drug / alcohol dependency
heart attack	prosthetic heart valve	lung disease	diabetes	kidney disease	
stroke		tuberculosis	stomach ulcers	thyroid disease	
		cancer	arthritis	diet pill therapy	

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?
   YES NO NOT SURE
18. Are there any diseases or medical problems that run in your family?
   YES NO NOT SURE
19. Do you smoke or chew tobacco products?
   YES NO NOT SURE
20. Are you nervous during dental treatment?
   YES NO NOT SURE
21. **For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
   YES NO NOT SURE

(Please continue on to Dental History – Thank you)

Dental History

1. What is the reason for today's visit? Complete Checkup Emergency Other
2. How frequently do you see the dentist? 3-6 months Annually Other
3. When was your last dental visit? Last set of x-rays?
4. How often do you brush per day? Floss? Use anti-bacterial mouthwash?
5. Are your teeth sensitive to : Cold Sweets Heat Other
6. Do your gums bleed when: Brushing Flossing Never
7. Do you snore? Any family history of sleep apnea? YES NO NOT SURE
8. Do you have bad breath or a bad taste in your mouth? YES NO NOT SURE
9. Do your jaws crack, pop or grate when you open widely? YES NO NOT SURE
10. Do you grind or clench your teeth? YES NO NOT SURE
11. Do you have food catch between your teeth? YES NO NOT SURE
12. Have you ever had local anaesthetic (freezing)? Any complications? Please specify: YES NO NOT SURE
13. Have you ever had any problems with previous dental treatments? Please specify: YES NO NOT SURE
14. Have you ever had any of the following? Please check:

    Bridgework Crowns or Caps Root Filling or Root Canal
    Dentures Braces (Orthodontics) Gum Therapy (Periodontal)

15. Rate your smile from 1 to 10 (1 = very unsatisfied, 10 = very satisfied):

    ☹ 1 2 3 4 5 😐 6 7 8 9 10 ☺

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct to the best of my knowledge 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 provided at each visit for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. I authorize the electronic submission of benefit claims on my behalf to my insurance carrier. I consent to having photographs taken of me for record documentation and for illustration of my treatment. I authorize that these pictures may be used for lectures or publication by Dr. Pravir Patel. I consent to contact by email by the dental office for dental / community related purposes. *Missed appointments or cancellations with less than 2 days notice will be billed $50.*

PATIENT/PARENT/GUARDIAN: ______________________ DATE: __________
SIGNATURE PRINT NAME

DENTIST: ______________________ Dr. Pravir Patel DATE: __________
SIGNATURE PRINT NAME

DENTIST NOTES

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W –

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