WELCOME TO DIAMOND DENTAL CENTRE

NAME: MR./MISS/MRS./MS/DR. _____

DATE OF BIRTH (MONTH/DAY/YEAR): _____/_____/_____

ADDRESS (HOME): _____

CITY _____ POSTAL CODE: _____

PHONE (HOME): _____ PHONE (CELL): _____

E-MAIL: _____

OCCUPATION: _____ EMPLOYER: _____

ADDRESS (WORK): _____

CITY _____ POSTAL CODE: _____

PHONE (WORK): _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ MOBILE SIGN ☐ MAILER ☐ REFERRED BY (PLEASE NAME):_____

☐ SIGN ON OFFICE ☐ GOOGLE SEARCH ☐ WEBSITE ☐ YELLOWPAGES.CA

☐ OTHER_____

PREFERRED METHOD OF CONTACT:

☐ CALL HOME ☐ CALL CELL ☐ CALL WORK ☐ E-MAIL ☐ TEXT TO CELL

IN CASE OF EMERGENCY, PLEASE CONTACT: _____

RELATIONSHIP: _____ DAYTIME PHONE NUMBER(S):_____

MEDICAL DOCTOR: _____ PHONE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CO. NAME: _____ SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH (MONTH/DAY/YEAR) _____/_____/_____ RELATIONSHIP TO YOU: _____

SUBSCRIBER'S EMPLOYER: _____ POLICY #: _____ ID #_____

SECONDARY INSURANCE CO. NAME: _____ SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH (MONTH/DAY/YEAR) _____/_____/_____ RELATIONSHIP TO YOU: _____

SUBSCRIBER'S EMPLOYER: _____ POLICY #: _____ ID #_____

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THE FOLLOWING INFORMATION IS REQUIRED TO ENABLE US TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE. ALL INFORMATION IS STRICTLY PRIVATE AND IS PROTECTED BY DOCTOR-PATIENT CONFIDENTIALITY. DR. DIAMOND WILL REVIEW WITH YOU ANY QUESTIONS THAT YOU DO NOT UNDERSTAND. **PLEASE FILL IN THE ENTIRE FORM.**

DENTAL HISTORY QUESTIONNAIRE

1) WHEN WAS YOUR LAST DENTAL VISIT? _____
2) WHAT WAS DONE AT THAT TIME? _____
3) HAVE YOU EVER HAD ANY OF THE FOLLOWING TREATMENTS (PLEASE CIRCLE):
   ROOT CANAL ORTHODONTICS WHITENING FULL OR PARTIAL DENTURES
   EXTRACTIONS PERIODONTAL (GUM) SURGERY CROWNS/BRIDGEWORK
4) HAVE YOU EVER HAD A BAD OR UNPLEASANT DENTAL EXPERIENCE? _____
5) HOW WOULD YOU RATE YOUR CURRENT DENTAL STATE (PLEASE CIRCLE)?
   EXCELLENT GOOD AVERAGE POOR
6) DO YOU HAVE ANY OF THE FOLLOWING DENTAL CONCERNS:
   PAIN CLICKING OR PAIN IN JOINT (TMJ) BAD BREATH/TASTE MISSING TEETH
   SENSITIVITY TO COLD/HOT/SWEET BLEEDING TOOTH GRINDING/CLENCHING
   OTHER_____
7) IF YOU COULD CHANGE ANYTHING AT ALL ABOUT YOUR SMILE, WHAT WOULD IT BE?
   _____

please continue on other side ----->

[FOR OFFICE USE ONLY: **MEDICAL ALERT:** _____]

MEDICAL HISTORY QUESTIONNAIRE

1) ARE YOU BEING TREATED FOR ANY MEDICAL CONDITION AT THE PRESENT OR WITHIN THE PAST YEAR? (PLEASE CIRCLE) YES NO
2) WHEN WAS YOUR LAST MEDICAL CHECKUP? _____
3) HAS THERE BEEN ANY CHANGE IN YOUR HEALTH IN THE PAST YEAR? _____
   IF YES, PLEASE EXPLAIN _____
4) ARE YOU TAKING ANY MEDICATIONS, NON-PRESCRIPTION DRUGS OR HERBAL SUPPLEMENTS OF ANY KIND? (PLEASE CIRCLE) YES NO
   IF YES, PLEASE LIST_____
   _____
   _____
5) DO YOU HAVE ANY ALLERGIES TO ANY OF THE FOLLOWING:
   a) MEDICATIONS (PLEASE LIST): _____
   b) LATEX/RUBBER PRODUCTS: _____
   c) OTHER E.G. SEASONAL, FOODS (PLEASE LIST): _____
6) DO YOU HAVE OR HAVE YOU EVER HAD HEART OR BLOOD PRESSURE PROBLEMS? (PLEASE CIRCLE):
   YES NO
   IF YES, PLEASE EXPLAIN: _____
7) DO YOU HAVE OR HAVE YOU EVER HAD A HEART MURMUR, MITRAL VALVE PROLAPSE, OR RHEUMATIC FEVER? _____
8) DO YOU HAVE ANY PROSTHETICS OR ARTIFICIAL JOINTS? _____
9) HAVE YOU EVER BEEN ADVISED BY YOUR DOCTOR TO TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT? _____
10) DO YOU HAVE ANY CONDITIONS THAT COULD AFFECT YOUR IMMUNE SYSTEM E.G. LEUKEMIA, AIDS, HIV, RADIATION THERAPY, CHEMOTHERAPY? _____
11) HAVE YOU EVER HAD HEPATITIS, JAUNDICE, OR LIVER DISEASE? _____
12) DO YOU HAVE A BLEEDING PROBLEM OR DISORDER? _____
13) HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESSES OR OPERATIONS? _____ IF YES, PLEASE EXPLAIN_____
14) DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (PLEASE CIRCLE):
    CHEST PAIN HEART ATTACK STROKE ASTHMA SHORTNESS OF BREATH
    PROSTHETIC HEART VALVE PACEMAKER LUNG DISEASE TUBERCULOSIS
    CANCER DIABETES STOMACH ULCERS ARTHRITIS SEIZURES
    KIDNEY DISEASE THYROID DISEASE DRUG OR ALCOHOL DEPENDENCY
15) ARE THERE ANY CONDITIONS NOT LISTED THAT YOU HAVE OR HAVE HAD? _____
16) DO YOU SMOKE OR CHEW TOBACCO PRODUCTS? _____
17) FOR WOMEN ONLY: ARE YOU BREASTFEEDING OR PREGNANT? _____
    IF PREGNANT, AT WHAT STAGE? _____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT:

PATIENT/PARENT/GUARDIAN SIGNATURE: _____DATE_____

DENTIST SIGNATURE: _____DATE_____