ALLADINA DENTAL
143 Queen Street East, Suite 201, Brampton, ON, L6W 2B1
905-792-3096 reception.dralladina@gmail.com

Patient Information

Welcome to Alladina Dental! In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

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: _____/_____/_____ Email Address: _____
D M Y

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

How did you hear about us?_____

Emergency Contact: _____ Tel. (_____) _____
Family Doctor: _____ Tel. (_____) _____
Specialist Doctor: _____ Tel. (_____) _____

Financial Information

Method of payment: Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐
Person responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

PRIMARY INSURANCE
Ins. Company:_____ Tel. (_____) _____
Employer/Policy Holder: _____ Ins. Yr. End: _____
Policy#: _____ Certificate#: _____ ID#: _____

SECONDARY INSURANCE
Ins. Company:_____ Tel. (_____) _____
Employer/Policy Holder: _____ Ins. Yr. End: _____
Policy#: _____ Certificate#: _____ ID#: _____

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 rinse? _____
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 problems with previous dental treatments? Specify_____	☐	☐

14. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps ☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gums) ☐ Root Canal

15. Are you satisfied with your teeth? Specify _____	☐	☐

Medical History

This information will remain 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 _____ [D] Drug _____ Reason _____
[B] Drug _____ Reason _____ [E] Drug _____ Reason _____
[C] Drug _____ Reason _____ [F] Drug _____ Reason _____

4. Have you ever had any adverse effect to any of the following: **Antibiotics: Penicillin** ☐ , **Sulfonamide** ☐ , **Other** ☐ ;
Aspirin ☐ ; **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 any 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.**	☐ **Cortisone/steroid**	☐ **High/Low Blood pressure**	☐ **Psychiatric disorders**
☐ **Anemia**	☐ **Diabetes**	☐ **H.I.V. Positive**	☐ **Radiation/Chemotherapy**
☐ **Angina pectoris**	☐ **Drug/alcohol dependence**	☐ **Hodgkin disease**	☐ **Rheumatic/Scarlet fever**
☐ **Anorexia nervosa**	☐ **Emphysema**	☐ **Hyper (Hypo) Glycemia**	☐ **Sickle Cell disease**
☐ **Artificial Heart valve**	☐ **Epilepsy**	☐ **Hypertension**	☐ **Sinus trouble**
☐ **Arthritis/rheumatism**	☐ **Glandular disorders**	☐ **Jaundice**	☐ **Stomach/intestinal issues**
☐ **Artificial joints (hips, knees)**	☐ **Glaucoma**	☐ **Kidney disease**	☐ **Stroke**
☐ **Asthma**	☐ **Head/Neck injuries**	☐ **Liver disease**	☐ **Thyroid disease**
☐ **Blood disorders**	☐ **Heart disease/attack**	☐ **Leukemia**	☐ **Tuberculosis**
☐ **Bronchitis**	☐ **Heart murmur**	☐ **Lung disease**	☐ **Ulcers**
☐ **Bulimia**	☐ **Heart pacemaker/surgery**	☐ **Malignant hypothermia**	☐ **Venereal disease**
☐ **Cancer**	☐ **Heart rhythm disorder**	☐ **Mental/nervous disorder**	☐ **Other** _____
☐ **Circulation problems**	☐ **Hepatitis A/B/C**	☐ **Mitral valve prolapse**	☐ **Other** _____
☐ **Congenital heart lesions**	☐ **Herpes**	☐ **Organ transplant/implant**	☐ **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 of 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.

_____ _____ _____
Signature ☐ Patient ☐ Parent/Guardian Print name Date

Thank You