Welcome To Our Practice

NEW PATIENT INFORMATION FORM

SIDNEY HARBOUR DENTAL

First Name: _____ Last Name: _____

Date of Birth: _____ Preferred Name (optional) _____

Preferred Pronoun (optional) _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Care Card/Pharmacy Name: _____

How do you prefer to be contacted? ☐Cell ☐Home Phone ☐Email ☐Work Phone:

Who do we call in case of emergency? Name: _____ Phone: _____

Dental Insurance Name of the Insurance: _____ Secound Dental Insurance Name of the Insurance: _____

Policy #: _____ Policy #: _____

ID #: _____ ID #: _____

Name of the Policy holder: _____ Name of the Policy holder: _____

DOB: _____ DOB: _____

Who can we thank for referring you (how did you find out about our practice)?:

☐Patient: _____ (Relationship) _____ ☐Website

☐Online / Google Search ☐News Paper Ad ☐Walk by ☐External Signage

☐Social Media

Dental History

What is your primary concern today: _____

I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

Do you experience Dental anxiety: ☐Yes ☐No

Are you aware of any clenching or grinding? ☐Yes ☐No

Smile Characteristics

	YES	NO
Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐

MEDICAL HISTORY

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

Have you been instructed to take pre-medication(antibiotic) prior to dental treatment? _____

Do You Have or Have You Ever Had:	YES	NO
1. hospitalization for illness or injury in the last 3yrs.	☐	☐
i) an allergic reaction to:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ other _____		
ii) heart problems, or cardiac stent within the last six months _____	☐	☐
iii) history of infective endocarditis _____	☐	☐
iv) artificial heart valve, repaired heart defect (PFO) ____	☐	☐
v) pacemaker or implantable defibrillator _____	☐	☐
vi) high or low blood pressure _____	☐	☐
vii) a stroke _____	☐	☐
viii) high cholesterol _____	☐	☐
ix) orthopedic implant (joint replacement) _____	☐	☐
2. Cancer (Type) _____	☐	☐
i) radiation therapy _____	☐	☐
ii) chemotherapy, immunosuppressive medication ____	☐	☐
3. emphysema, shortness of breath _____	☐	☐
i) asthma _____	☐	☐
ii) breathing or sleep problems _____ (i.e. sleep apnea, snoring, sinus)	☐	☐
4. STI / STD / HPV _____	☐	☐
i) HIV / AIDS _____	☐	☐
ii) hepatitis (type ____) _____	☐	☐
iii) viral infections and cold sores _____	☐	☐
5. bisphosphonates _____	☐	☐
i) osteoporosis/osteopenia _____ (i.e. taking bisphosphonates)	☐	☐
ii) arthritis _____	☐	☐
iii) autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐

	YES	NO
6. stomach or duodenal ulcer _____	☐	☐
i) digestive disorders _____ (i.e. celiac disease, gastric reflux)	☐	☐
7. anemia or other blood disorder _____	☐	☐
i) kidney disease _____	☐	☐
ii) liver disease _____	☐	☐
iii) thyroid disease	☐	☐
iv) diabetes (HbA1c = Type 1 or 2) _____	☐	☐
8. epilepsy, convulsions (seizures) _____	☐	☐
i) neurologic disorders _____ (ADD/ADHD)	☐	☐
ii) mental illness _____	☐	☐
iii) alcohol / recreational drug use _____	☐	☐
iv) Alcohol or drug Dependancy Please specify _____	☐	☐
v) Are you A Smoker present or past _____ (Cigarette, Vaping Cigarette or Cannabis)	☐	☐
9. head or neck injuries _____	☐	☐
i) any lumps or swelling in the mouth _____	☐	☐
10. Do you often fell exhausted or fatigued?	☐	☐
i) Do you experience frequent headaches?	☐	☐
11. Are you currently pregnant?	☐	☐
12. Any other illness/condition not mentioned above?	☐	☐

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MEDICAL HISTORY

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.

_____

_____

_____

_____

List all Current medications, supplements, and or vitamins taken

Please advise us in the future of any change in your medical history or any medications you may be taking.

Drug	Purpose	Drug	Purpose

Your Privacy is Always Assured

Privacy of our patient's personal information is important to us. Personal information is necessary for providing professional oral health care services to you and information necessary to administer your dental treatment.

I authorize communication of this personal information by mail, electronic and verbal means. Personal information includes clinical records, X-rays, study models, photographs of you and your teeth, mouth, smile and face, and general health information obtained from a medical history review, insurance information, phone numbers and email addresses. Clinical information and photographs, x-rays may also be used for long-term follow-up and research purposes, as well as for education or teaching purposes.

Your personal information will only be shared with those who have a need to know and specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include referring dentists, other dental specialists, physician(s), dental laboratories and insurance carriers.

I certify that I have read and understand this document.

Patient Signature / Parent / Guardian _____ Date: _____

Doctor's or RDH Signature _____ Date _____