Personal Information

Uxbridge Family Dentistry
DR MICHAEL BANH & ASSOCIATES

1. ABOUT YOU

Today's Date: _____

Date of Birth (DD/MM/YY): _____

Name: _____
(First) (MI) (Last)

I prefer to be addressed as: _____

(please check) ☐ Male ☐ Female

☐Dr ☐Mr ☐Mrs ☐Miss ☐Ms

☐Single ☐Married ☐Common Law

Home Address: _____

City:_____ **Postal Code:** _____

Email: _____

Home No.:_____

Cell No.: _____

Work No.:_____ **Ext.**_____

May we contact you at work? ☐Yes ☐No

For appointment reminders, which do you prefer?:

☐ E-mail **OR** ☐ Phone (Please circle: Home / Cell / Work)

Employer: _____

Occupation: _____

In case of an emergency, whom should we contact?

Name: _____

Relation: _____

Home/Cell No:_____

Work:_____ Ext._____

How did you hear about us?:

☐ Friend/Family: _____

☐ Google: (search terms used: _____)

☐ Website ☐ Facebook ☐ Twitter ☐ Yellow Pages

☐ GoldBook ☐ Other: _____

2. FINANCIAL INFO

Person responsible for account:

☐ Self ☐Spouse/Partner ☐ Other

If Spouse/Partner/Other:

Name: _____

Billing Address (If different from above):

_____

City:_____ Postal Code: _____

Employer: _____

Cell No.: _____

Work No._____ Ext.: _____

3. INSURANCE INFO ☐No Insurance

1st Insurance Company: _____

Employee Name: _____

Date of Birth:_____

Employer: _____

Plan/Policy No.:_____

I.D./Cert. No.: _____

2nd Insurance Company: _____

Employee Name: _____

Date of Birth:_____

Employer: _____

Plan/Policy No.:_____

I.D./Cert. No.:_____

I authorize release to my dental benefits plan administrator, and CDA, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revoked the same.

☐ Check here to allow printed name below as signature

_____
Signature of Subscriber/Patient or Guardian

Date: _____

Dental Information

Uxbridge Family Dentistry
DR MICHAEL BANH & ASSOCIATES

4. IMMEDIATE DENTAL NEEDS

What brings you here today? ☐Check-up ☐Specific Problem
☐Other:_____

_____

Please check below if you have pain or problems with:

☐Hot ☐Cold ☐Sweets ☐Chewing ☐Broken Teeth

☐Bleeding Gums ☐Bad Breath ☐Bad Taste ☐Food Trapping
☐Other: _____

5. DENTAL HISTORY

When was your last dentist visit?:
☐Never ☐6 months ☐1 year ☐2 years ☐3+ years

Why are you changing dentists: _____

_____

What treatment did you receive? ☐Check-up ☐Basic Fillings
☐Crown/Bridge ☐Root Canal ☐Other: _____

Have you ever had?:
☐Dental Implant(s) ☐Braces ☐Gum Surgery ☐Night Guard
☐Sports Guard ☐Dry Mouth

	YES	NO
Do you grind or clench you teeth (day or night)?:	☐	☐
Do you play contact sports (eg. Hockey, rugby)?:	☐	☐
Are you being followed by a dental specialist?:	☐	☐

If yes, type of specialist:
☐Oral Surgeon ☐Periodontist ☐Orthodontist
☐Other: _____
Specialist's Name:_____

Is there anything that you don't like about dental visits?
☐Discomfort ☐Fear ☐Fees ☐Time ☐Inconvenience
☐Other (explain) _____

_____

6. HYGIENE HABITS

How often do you brush your teeth?:
☐Never ☐1x/day ☐2x/day ☐>2x/day

How often do you floss?:
☐What's floss? ☐Seldom ☐1x/day

What toothbrush do you use?:
☐Manual ☐Electric: _____

Which toothpaste do you use?:

_____

Do you use mouthwash?:
☐Yes ☐No ☐Occasionally
If Yes, which one: _____

7. YOUR SMILE

Are you happy with your smile?:
☐Yes ☐No

What would you change if anything?
☐Colour ☐Shape ☐ Alignment
☐Other: _____

_____

_____

8. YOUR DIET

Do you regularly eat/drink …?	Y	N
coffee/tea (with sugar or honey)	☐	☐
pop (eg: coke/pepsi, etc…)	☐	☐
energy drinks (eg:red bull/monster)	☐	☐
juices (eg: apple/orange. etc)	☐	☐
candy / mints / toffees / chocolate	☐	☐

Medical Information

Uxbridge Family Dentistry
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9. HEALTH HISTORY

Today's Date: _____ **Date of Birth:** _____

Patient Name:_____
(First) (MI) (Last)

Current Physician: _____

City:_____ **Phone:** _____

Please circle if you have had allergic reactions to the following:

Aspirin	Codeine	Metals/Jewellery	Penicillin	Sulfa
Anesthetic	Erythromycin	Latex	Sleeping pills	Tetracycline

Other (Explain): _____

If any circled above, please describe symptoms:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list ALL medications you are currently taking:

Medications:	**Dose**	**Reason for taking**

		Y	**N**
Are you:	taking birth control pills or hormone replacement?	☐	☐
	pregnant?	☐	☐
	nursing?	☐	☐
Have you:	been told you need antibiotics before dental visits?	☐	☐
	ever taken medication to prevent osteoporosis?	☐	☐
	had radiation therapy of the *head and/or neck*?	☐	☐
	had chemotherapy? (Date: _____)	☐	☐
	had artificial joint replacement? (Date: _____)	☐	☐
Do you smoke?	If so, How much? _____ How many years? _____	☐	☐

10. CONDITIONS

Check below if you have ever had any of the following:

Heart Conditions:
- ☐ Artificial valve/stent/prosthetics
- ☐ Infective endocarditis
- ☐ Cyanotic congenital heart disease
- ☐ Cardiac transplant

☐ Angina
☐ Heart Attack
☐ Stroke
☐ Pacemaker
☐ High Blood Pressure (reading:___ /___)
☐ Low Blood Pressure (reading:___ /___)
☐ Alzheimer's / Memory loss
☐ Anemia
☐ Anorexia / Bulimia
☐ Arthritis
☐ Asthma / Hay Fever
☐ Cancer
☐ Cold Sores / Herpes
☐ Diabetes
☐ Difficulty Breathing
☐ Drug / Alcohol abuse
☐ Emphysema
☐ Epilepsy / Seizures / Fainting
☐ Acid Reflux / GERD / Stomach Ulcer
☐ Glaucoma (Narrow Angle)
☐ Headaches (Frequent, severe)
☐ Hearing Impairment
☐ Hemophilia / Bleeding disorder
☐ Hepatitis A B C or D
☐ HIV / AIDS or contact with the virus
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Malignant Hyperthermia
☐ Organ Transplant
☐ Prostate Disorder
☐ Radiation Treatment
☐ Recreational Drugs (Marijuana, Meth, etc..)
☐ Shingles
☐ Smoking / Tobacco
☐ Snoring / Sleep apnea
☐ Thyroid / Parathyroid disorder
☐ Tuberculosis
☐ Tumour / Abnormal Growth
☐ Venereal Disease: _____
☐ Other:_____
_____

I, _____, hereby certify that all information I have given is true to the best of my knowledge, and I have not knowingly omitted any information.

Signature:_____ ☐ *

Date:_____

Reviewed by:_____

* Check here to allow printed name above as signature