Patient Information – age 16+

Last name: ________ **First name:** ________ **Preferred name:** ________ **Title:** ________

Male ☐ Female ☐ Gender neutral ☐ Married ☐ Single ☐ Other ☐

Birth date (DD/MM/YYYY): ________ **N.S. health card number:** ________

Who do we contact to schedule appointments? (full name) ________

Preferred method of contact: E-mail ☐ Home # ☐ Mobile # ☐ Work # ☐ Text msg ☐

Home ph: ________ **Mobile ph:** ________ **Work ph:** ________ **Ext.** ________

E-mail address for automated reminders: ________

Address: ________ **City:** ________ **Postal code:** ________

Please indicate why you chose our office

Friend recommendation/referral (please specify so that we may thank them)	
Family comes here	
Convenient location	
Internet (Google, Rate MDs, our website, Facebook, etc.) --- please specify	

Insurance Information

Dental insurance company name | policy | ID numbers: ________ | ________ | ________

(Provide secondary insurance plan information to receptionist)

Name/date of birth of plan member: ________

Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Medical Information

Medical doctor ________ **Phone:** ________ **Last medical exam?** ________

Previous dentist ________ **Phone:** ________ **Last dental exam?** ________

MEDICATIONS: list prescription **AND** non-prescription medications (or provide list from pharmacy)

____

ALLERGIES: list all allergies or adverse reactions to **ANY** substance (see examples listed below that should be considered)

____

Local anesthetics	Antibiotics	Aspirin	Ibuprofen	Tylenol	Nickel/other metals
Other NSAIDS	Narcotics	Sulfa drugs	Foods	Codeine	Latex

GENERAL HEALTH: For the following questions, circle yes or no:

Are you generally in good health?	Yes	No
Have there been any changes in general health within the year?	Yes	No
Are you now under physician care?	Yes	No
Have you ever had a serious illness or operation?	Yes	No
Have you been hospitalized within the past 5 years?	Yes	No
Do you have an infectious or communicable disease?	Yes	No

CARDIOVASCULAR SYSTEM: Please indicate if you have, or have ever had, any of the following: (circle)

Heart trouble	Heart attack	Stroke	Congenital heart disease
Chest pains	Angina pectoris	Endocarditis	Rheumatic heart disease
Arteriosclerosis	Heart palpitations	Low blood pressure	High blood pressure
Cardiac pacemaker	Damaged heart valves	High cholesterol	Jaundice
Blood disorders	Anemia/Sickle cell	Hemophilia	
Bruise easily	Abnormal bleeding		

Last blood pressure reading: ____________________________ Date: ____________________________

CENTRAL NERVOUS SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Epilepsy or other seizures	Numbness or tingling sensations	Head trauma	Bipolar disorder
Depression	Schizophrenia	Emotional disturbances	Concussion
Neurological disorder	Anxiety	Eating disorder	Fainting spells

Other mental disorder ____

RESPIRATORY SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Tuberculosis	Sinusitis or sinus trouble	Emphysema
Bronchitis	Asthma	Shortness of breath

GASTROINTESTINAL SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Kidney/bladder problems	Liver disease	Stomach ulcers
Irritable bowel syndrome	Crohn’s or colitis	Celiac

ENDOCRINE SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Diabetes	Hypothyroidism	Hyperthyroidism

SKELETAL SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Osteoarthritis	Rheumatoid arthritis	Bone infection	Implants
Bone density issues	Osteoporosis	Temporomandibular joint disorder	Artificial joints
History of broken bones	Osteopenia	Dysfunction	____________________________

NEOPLASMS: Please indicate if you have or have ever had any of the following:(circle)

Cancer, tumour or malignancy ________________________ Chemotherapy or radiation therapy ________________________

INFECTION OR COMMUNICABLE DISEASE: Please indicate if you have or have ever had any of the following: (circle)

Sexually-transmitted diseases	Creutzfeldt-Jakob disease	HIV/AIDS
Hepatitis	Rheumatic fever	Other Transmissible Spongiform Encephalopathy

IMMUNE SYSTEM: Please indicate if you have any of the following: (circle)

Asthma   Hay Fever   Hives or skin rash   Anaphylaxis   Swelling around the mouth

INFORMATION TO MAKE YOUR APPOINTMENTS BETTER: Indicate if you have any of the following: (circle)

Trouble hearing	Trouble seeing	History of ear, nose, and throat problems
Persistent thirst	Severe headaches	Can't lie down all the way
Difficulty swallowing	Acid reflux	Recent change of appetite
Frequent vomiting	Extra pillows to sleep	Urinate more than 6 times per day
Headaches	Sinus troubles	Tendency to faint
Hard to freeze	Jaw stiffness	

WOMEN: Indicate if any of the following applies to you: (circle)

Pregnant   Nursing   Birth control pills   Hormonal therapy   Post-menopausal

OTHER: Is there anything else concerning your health that you think the dentist should know about?

____

Dental Questionnaire

Question	Yes		No		
Do you have any discomfort or pain in your mouth?	Yes	☐	No	☐	____________
Are you able to eat and chew foods satisfactorily?	Yes	☐	No	☐	____________
Do you have any problems with your jaw joints?	Yes	☐	No	☐	____________
Do you have any problems with your bite?	Yes	☐	No	☐	____________
Have you had problems with previous dental treatment?	Yes	☐	No	☐	____________
Do you experience tooth sensitivity to cold or hot liquids?	Yes	☐	No	☐	____________
Are you satisfied with the appearance of your teeth?	Yes	☐	No	☐	____________
Are you happy with the colour of your teeth?	Yes	☐	No	☐	____________
Are you interested in discussing bleaching options?	Yes	☐	No	☐	____________
Are you interested in discussing teeth-straightening options?	Yes	☐	No	☐	____________
Are you interested in discussing cosmetic dentistry options?	Yes	☐	No	☐	____________

Do you do any of the following? (circle)

Drink tea	Drink coffee	Drink alcohol	Smoke tobacco	Use cannabis
Grinding/clenching	Snoring	Thumb-sucking	Chew fingernails	Recreational drugs

Do you currently have or have you ever had in the past: (circle)

Facial pain	Sleep apnea	Jaw Pain	Headaches
Bleeding gums	Sensitive teeth	Earaches	Neck Pain
Braces	Invisalign	Retainers	Mouth guard
Biteplane/night guard	Dentures/Partials	Crowns/bridges	Implants

For the following questions, please check the response that best describes your situation:

1. I usually go to the dentist every:

☐ 3-4 months ☐ 6-12 months ☐ a year or more between visits ☐ I only go when I'm in pain

2. I routinely use the following dental products:

Manual toothbrush:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Electric toothbrush:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Dental floss:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Mouthwash:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never

3. I suffer from dental anxiety: (circle)

Not at all Mild Moderate Severe

4. Which one of the following situations best describes your attitude toward treatment?

☐ I am willing to do whatever it takes to save a tooth.
☐ My decision to save a tooth relies heavily on what it costs and the time commitment required.
☐ My decision to save a tooth relies heavily on whether it is covered by insurance.
☐ I would rather have it extracted.

Any other concerns or anything else you'd like us to know? ____

Authorization and Consent Form

______ To the best of my knowledge, the medical and dental history provided is true and correct. I will provide information on changes in health.

______ I authorize the diagnosis of dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

______ I give consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by her supervised staff for diagnostic purposes or dental treatment.

______ I authorize the dentist to release information to other healthcare practitioners and insurance carriers. If there is a specific person(s) who should <u>not</u> receive the patient's dental records, please notify us.

______ I am financially responsible for ALL services provided; payment-in-full is expected on the day of my visit. Bedford South Dentistry will send dental claims online; benefits will be paid to the plan member.

______ I understand that the dentist and staff do not know the details of my dental benefits plan as it is protected under privacy regulations. It is my responsibility to understand my plan.

***A charge of $80 will apply for failure to attend a pre-booked appointment or for failure to provide at least 48 hours' notice (2 business days) for schedule changes. This policy is essential for the efficient functioning of our dental office.**

Patient/guardian sign and date: __________________________________Print: _________________________________

Dentist signature and date: ____

Bedford South Dentistry: Patient Records Release Consent

Transfer of records from:

Previous dentist: ______________________________

Address: ______________________________

Fax number: ______________________________

E-mail address:
(even better! ☺) ______________________________

New dentist: Dr. Natalie Brothers Dr. Jillian Reynolds Dr. Bonnie Theriault Dr. Allison Thibault
(circle)

Address: Bedford South Dentistry
15 Peakview Way, Suite 300, Bedford, N.S. B3M 0G2
Phone: (902) 433-6825 Fax: (902) 835-3831

E-mail: reception@bedfordsouthdentistry.com

*****IF YOU ARE ABLE, PLEASE SEND X-RAYS IN DEXIS FORMAT*****

I hereby give authorization to release a copy of my dental records to the above-named dentist.

Patient(s) (family) name(s) PLEASE PRINT	Patient(s) dates of birth USE DAY/ MONTH/YEAR FORMAT

Patient address: ______________________________

Patient phone: ______________________________

Patient signature: ______________________________

Date: ______________________________