

## 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

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

**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:   | <input type="checkbox"/> | Two or more times a day | <input type="checkbox"/> | Once a day | <input type="checkbox"/> | Three times a week | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Never |
| Electric toothbrush: | <input type="checkbox"/> | Two or more times a day | <input type="checkbox"/> | Once a day | <input type="checkbox"/> | Three times a week | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Never |
| Dental floss:        | <input type="checkbox"/> | Two or more times a day | <input type="checkbox"/> | Once a day | <input type="checkbox"/> | Three times a week | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Never |
| Mouthwash:           | <input type="checkbox"/> | Two or more times a day | <input type="checkbox"/> | Once a day | <input type="checkbox"/> | Three times a week | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Never |

3. I suffer from dental anxiety: (circle)

- Not at all    Mild    Moderate    Severe    Would you be interested in learning about Nitrous Oxide-assisted dentistry? (y/n)

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 not 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 \$50 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:**  
**(circle)**

Dr. Natalie Brothers   Dr. Jillian Reynolds   Dr. Bonnie Theriault   Dr. Allison Thibault

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

**Patient address:**

**Patient phone:**

**Patient  
signature:**

**Date:**