NEW PATIENT FORM

Treehouse Dental Care

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

PATIENT NAME (SURNAME, GIVEN): **PREFERRED NAME:**

BIRTHDATE (DD/MM/YY): SEX: SCHOOL:

HOME ADDRESS (NO, STREET, CITY PROVINCE): POSTAL CODE:

HOME PHONE: OTHER PHONE: EMAIL:

May we leave a voicemail regarding your appointment at these numbers? ☐ Yes ☐ No

ARE YOUR LIKELY TO BE AVAILABLE ON SHORT NOTICE FOR FUTURE APPOINTMENTS OR CHANGES? ☐ Yes ☐ No

We would like to send you email and text communications which may include appointment confirmations, newsletters upcoming events, and important notifications. **Check the box if you would like to receive future email and text communications from us.** ☐

FAMILY PHYSICIAN: PHONE:

IN CASE OF EMERGENCY NOTIFY: RELATION: PHONE:

PARENT/GUARDIAN/CAREGIVER INFORMATION:

NAME (SURNAME, GIVEN) RELATION:

ADDRESS (NO, STREET, CITY, PROVINCE): PHONE:

OCCUPATION: WORK PHONE:

PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE (E.g. SCHEDULING APPOINTMENTS):

NAME: RELATION:

HOW DID YOU HEAR ABOUT US? Referred from an existing patient or staff member (family, friend or colleague), internet, community, professional referral (another health care professional), emergency/walk-in or other:

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours' notice, otherwise it may be necessary to charge for the time lost.

(Signature) PARENT☐ GUARDIAN☐ CAREGIVER☐ DATE

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INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE PROVIDE THE INSURANCE INFORMATION FOR ONE OR BOTH POLICIES.

Dental History:

Last dental visit: _____

How often does the patient brush his/her teeth? _____ Floss his/her teeth? _____

Does the patient experience any pain or discomfort in the mouth? .....Y □ N □ O □

Has the patient ever experienced any growths, lumps or sore spots in his/her mouth?.....Y □ N □ O □

Has the patient had previous problems with dental treatment? .....Y □ N □ O □

Is the patient satisfied with the appearance of his/her teeth? .....Y □ N □ O □

Is the patient nervous during dental treatment? .....Y □ N □ O □

MEDICAL HISTORY (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

1. Is the patient in good health? If no, please explain.....Y □ N □ O □

   _____

2. When was the last time the patient had a medical examination? _____

   Were any problems identified? .....Y □ N □ O □ If yes, please explain:

   _____

3. Does the patient take any supplements or medication on a daily basis?..... Y □ N □ O □
4. Does the patient have any allergies? .....Y □ N □ O □

   If yes, please list using the categories below:

   Medications/Latex/rubber products/Other (e.g. hay fever, foods)

   _____

5. Has the patient had any adverse reaction to any medicines, injections or dental local anesthetic?.....Y □ N □ O □

   If yes, please explain: _____

6. Does the patient have or has the patient ever had a replacement or a repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Y □ N □ O □

   If yes, please explain: _____

7. Has the patient ever been advised to take antibiotic pre-medication prior to dental treatment?.....Y □ N □ O □

   If yes, please explain: _____

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8. Does the patient have any conditions or is the patient undergoing any therapies that could affect his/her immune system? (E.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy) .....Y □ N □ O □

9. Has the patient ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders? .....Y □ N □ O □

10. Does the patient have a bleeding problem, bleeding disorder or bruising tendency? .....Y □ N □ O □

11. Does the patient have any or has the patient ever had any of the following (circle all that apply):

a. Fainting / Dizzy spells
b. Eating disorder
c. Stroke
d. Rheumatic fever
e. Mitral valve prolapse
f. Heart problems, murmur
g. Asthma or Emphysema
h. Pacemaker
i. Lung disease
j. Tuberculosis
k. Cancer
l. Steroid therapy
m. Diabetes
n. Stomach ulcers
o. High blood pressure
p. Arthritis / Rheumatism
q. Seizures / Epilepsy y.
r. Kidney disease
s. Thyroid disease
t. High / Low blood pressure
u. Hyper / Hypoglycemia
v. Mental or Nervous disorder
w. Circulatory problems
x. Blood transfusion
y. Other communicable disease / Transmissible infection

12. Are there any conditions or diseases not listed above that the patient has or has had? .....Y □ N □ O □

If yes, please provide details: _____

13. Is there any additional information related to the patient's health that has not been addressed above?

_____

_____

SEDATION AND SLEEP DENTISTRY:

For appointments when Sedation or General Anesthesia will be used, Treehouse Dental Care will provide the patient with the necessary information as there is specific preparation that MUST be followed prior to the patient's appointment. If the appointment is refused due to a full stomach, a fee will be charged for lost time.

_____ _____

(Signature) PARENT □ GUARDIAN □ CAREGIVER □ DATE

_____ _____

(Reviewed by Dentist) DATE