Dentistry at Lefroy

Medical/Dental History

1299 Killarney Beach Rd, PO Box 431
Lefroy, Ontario L0L 1W0
T: 705.290.5000 | F: 705.290.5001
contact@dentistryatlefroy.com

Patient Information

Last Name	First Name	
Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr	Preferred Name	
Gender ☐ Male ☐ Female ☐ Undetermined	Date of Birth DAY / MONTH / YEAR	
Address	Town	Postal Code
Home Phone ( ) -	Cell Phone ( ) -	
Email	Preferred method of contact ☐ Phone ☐ Text ☐ Email	
Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced	Occupation	

How did you hear about us?

☐ Friend's Name _____ ☐ Facebook ☐ Instagram

☐ Google ☐ Flyer ☐ Other _____

Child Patient

Mother's Name	Cell Phone ( ) -
Father's Name	Cell Phone ( ) -

In case of emergency, we should notify

Name	Relationship	Phone ( ) -

Other Information

Dental Insurance? ☐ No ☐ Yes	Plan	ID
OHIP Health Card #	Driver's Licence #	
Prior Dentist's Name	Office Address	Office Phone ( ) -
Family Doctor's Name	Office Address	Office Phone ( ) -

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by dentist-patient confidentiality. Your dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Dental Health

What is the reason for your visit today?

_____

Do have any concerns with the function or appearance your mouth, teeth, or smile? ☐ Yes ☐ No ☐ Not Sure

If yes, please explain what you would like to change _____

When was your last visit to the dentist? What dental treatment was done?

DAY / MONTH / YEAR _____

How often do you have dental visits?

☐ 2+ times a year ☐ once a year ☐ every 2-3 years ☐ rarely

How frequently do you brush your teeth?

☐ 3+ times a day ☐ twice a day ☐ once a day ☐ weekly ☐ rarely

How frequently do you floss your teeth?

☐ 1+ times a day ☐ 2-6 times weekly ☐ 1-6 times monthly ☐ rarely ☐ never

Do you have neck or jaw pain? ☐ Yes ☐ No ☐ Not Sure

Do you think you grind your teeth? ☐ Yes ☐ No ☐ Not Sure

Do you have sinus or ear problems? ☐ Yes ☐ No ☐ Not Sure

Do you get headaches or migraines? ☐ Yes ☐ No ☐ Not Sure

General Health

1. Are you being treated for any medical condition at the present or have you been treated within the past two years? ☐ Yes ☐ No ☐ Not Sure
   If yes, for what? _____
2. Has there been any change in your general health in the past two years? ☐ Yes ☐ No ☐ Not Sure
   If yes, please explain _____
3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ Yes ☐ No ☐ Not Sure
   If yes, please list the name and dosage:

   1. _____ 2. _____ 3. _____
   4. _____ 5. _____ 6. _____
   7. _____ 8. _____ 9. _____
   10. _____ 11. _____ 12. _____

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4. Do you have any allergic (or adverse) reactions to any medications or substances, including injections? ☐ Yes ☐ No ☐ Not Sure
   If yes, please list using categories below:
   a) medications _____
   a) latex / rubber products _____
   a) foods _____
   a) environmental _____
5. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No ☐ Not Sure
6. Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not Sure
7. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No ☐ Not Sure
8. Do you have or have you ever had a heart murmur, mitral valve prolapse, or rheumatic fever? ☐ Yes ☐ No ☐ Not Sure
9. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not Sure
10. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ☐ Yes ☐ No ☐ Not Sure
11. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not Sure
12. Have you ever been hospitalized for illness or operations? ☐ Yes ☐ No ☐ Not Sure
    If yes, please explain _____
13. Do you have or have you ever had any of the following? Please check

☐ Arthritis	☐ Drug/alcohol dependency	☐ Pacemaker	☐ Steroid therapy
☐ Cancer	☐ Heart attack	☐ Prosthetic heart valve	☐ Stomach ulcers
☐ Chest pain, angina	☐ Heartburn, acid reflux	☐ Seizures (epilepsy)	☐ Stroke
☐ Diabetes	☐ Hepatitis, jaundice, or liver disease	☐ Shortness of breath	☐ Thyroid disease
☐ Diet pill therapy	☐ Kidney disease	☐ Sleep disorders, sleepwalk, sleep apnea, snoring	☐ Tuberculosis
	☐ Lung disease		

14. Are there any conditions/diseases not listed above that you have or have had? ☐ Yes ☐ No ☐ Not Sure
    If yes, please specify _____
15. Are there any diseases or medical problems in your family (e.g. diabetes, cancer, heart disease)? ☐ Yes ☐ No ☐ Not Sure
    If yes, please specify _____
16. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure
17. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not Sure
18. **For women only**:
    a) Are you pregnant? ☐ Yes ☐ No ☐ Not Sure ... If pregnant, what is the expected delivery date? DAY / MONTH / YEAR
    b) Are you breastfeeding? ☐ Yes ☐ No

GENERAL RELEASE (Please sign after completing medical questionnaire)

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge the above information in correct. Should further information be needed by Dentistry at Lefroy, you have my permission to ask the representative health care provider to release such information. I will notify Dentistry at Lefroy of any change in my health or medication.

_____ DAY / MONTH / YEAR _____

Patient/Parent/Guardian Signature | Date | Dentist Signature

Dentist's Notes: **OFFICE USE ONLY**