TILBURY
DENTAL CARE
DR. CHAD DENOMME

Health History Form:

Dr.☐ Mr.☐ Mrs.☐ Ms.☐ Miss.☐

Name:_____ Email:_____
first *middle* *last*

Date of Birth: _____ Age:____ *Phone: (H)*_____*(C)*_____
mm/dd/yyyy

Address:_____
 # street *city* *province* *postal code*

Physican's Name_____ Physician's Phone Number_____

Have you been hospitalized in the last 5 years? Y / N *Explain*_____
Have you ever had extensive medical care or major surgery? Y / N *Explain*_____
Do you have any **ALLERGIES**? (ie. Antibiotics, metal, latex) ? Y / N *Explain*_____
Have you ever experienced any unusual reaction to any of the following? (***circle)***
Local Anesthesia (freezing), Aspirin, Penicillin, Iodine, Sulfonamide, Barbiturates, or any other medications?
*Explain*_____
Have you ever been advised not to take a certain drug or medication? Y / N *Explain*_____
_____

Do you have or have you ever had any of the following? (*please check all that apply)*

☐Heart Murmur or Mitral Valve Prolapse	☐ Malignant Hyperthermia	☐AIDS	☐Liver Disease
☐Stomach/intestinal problems	☐ Drug/Alcohol Addiction	☐Positive Testing for HIV virus	☐Herpes
☐Jaundice	☐Venereal Disease	☐Heart Attack	☐Hepatitis A/B/C
☐Mental or Nervous Disorder	☐Any Lung Disease	☐Cortisone/Steroid Therapy	☐Cold Sores
☐Sinus Trouble	☐High/Low Blood Pressure	☐Thyroid Disease	☐Diabetes
☐Cancer	☐Hyper/Hypoglycemia	☐Arthritis or Rheumatism	☐Tuberculosis
☐Kidney Disease	☐Epilepsy or Seizures	☐Scarlet or Rheumatic Fever	☐Stroke

☐Joint Replacements (knee, hip) Date of surgery_____
Other_____

Please circle either Yes or No with each question:

Have you ever had any known contact with the AIDS virus? Y / N *Explain*_____
Has any member of your family had diabetes? Y / N *Explain* _____
Do your ankles swell during the day? Y / N *Explain* _____
Have you had any sudden weight changes recently? Y / N *Explain*_____
Do you have any blood disorders such as haemophilia, thalassemia, anemia? Y / N *Explain*_____
Have you ever-experienced chemotherapy or radiation therapy? Y / N *Explain*_____
Have you ever had an injury, surgery or radiation therapy to your face or jaw? Y / N *Explain*_____
Is your eyesight: Good Adequate Poor Do you wear contact lenses? Y / N
Have you ever fainted? Y / N *Explain*_____
Do you ever experience shortness of breath or chest pain? Y / N *Explain*_____
Have you had any organ transplants or medical implants? Y / N *Explain*_____
Do you have any disease, condition or past medical history that the doctor should know about? Y / N
*Explain*_____

Have you ever been diagnosed or treated for Osteoporosis or Osteopenia? Y / N *Explain*_____
Have you ever taken any of the following medications?

Etdronate (Didronel)	Y / N	Ibandronate (Boniva)	Y / N
Tiludronate (Skelid)	Y / N	Pamidronate (Aredia)	Y / N
Alendronate (Fosamax)	Y / N	Zoledronate (Zometa)	Y / N
Risedronate (Actonel)	Y / N		

Female Patients

Are you pregnant? Y / N If yes, which month are you in?_____ Name of Obstetrician_____
Are you taking any birth control pills? Y / N *If yes, explain* _____

MEDICATIONS: *Please list all prescriptions, non-prescription medications including dose and frequency currently taking.*

Please List	*FOR OFFICE USE*						
MEDICATIONS	*Date*	*Date*	*Date*	*Date*	*Date*	*Date*	*Date*

Dental History:

Do you like your smile? Y / N What would you like to change? _____
Is there a dental problem you would like to have taken care of as soon as possible? Explain_____
How frequently do you visit your dentist? (*circle one)* 3 months 6months 9months Once a year Other_____
Name of former dentist _____Last dental visit_____
Have you been given oral hygiene instruction in Brushing? Y / N Flossing Y / N
How often do you Brush your teeth? _____ How often do you floss?_____
Other cleaning aids used: Stimudents Y / N Waterpick Y / N Toothpick Y / N Other_____
Are any of your teeth sensitive to: Cold Y / N Hot Y / N Sweets Y / N Location_____
Do your gums bleed: Y / N Spontaneously Y / N

Have you ever had or do you now have any of the following? (***please circle***)

Bridges	Lost Fillings	Gum Treatments
Partial Denture	Extractions	Swelling or pain in your mouth or jaws
Gag easily	Full Dentures	Loose Teeth
Root Canals	Orthodontic Treatment	Injury to face or jaw
Dental Implants	Bite Adjustment	Surgery in your mouth

Do you ever wake up with a headache or swore jaw? Y / N
Do you clench/grind your teeth at all through out the day/night? Y / N *Explain*_____
Do you currently wear a night guard or any other dental apparatus? Y / N *Explain*_____
Do you snore heavily throughout the night? Y/N Explain_____
Does your jaw crack or pop when opening/closing? Y / N *Explain*_____
Do you only chew on one side of your mouth? Y / N *Explain*_____
Have you experienced any growths or sore spots in your mouth? Y / N *Explain*_____
Do you smoke? Y / N (***circle* if yes)** cigarettes, cigars, pipes, other_____ Pack per day_____
Are you interested in quitting? Y / N

Circle any of the following that you are interested in:

Orthodontics	Repairing chipped teeth	Improved gum health	Bonding
Bleaching	Improving your bite	Closing spaces	Crowns
Improving breath odour	Replacing missing teeth	Sports mouth guard	Improving your smile

We will file your insurance electronically at no charge as well as make every effort to ensure you receive your maximum benefits. Please note it is your responsibility to provide us with any updates to your insurance coverage as you receive the changes. If you have any questions or concerns regarding your insurance please contact your insurance company directly for answers. Payment is due at the time of service. We accept cash, mastercard, visa and debit for the balance on your account that may not be covered by your insurance.
If you are not able to make your scheduled appointment, we require a 48 hour notice to avoid charges.
I hereby certify that the above information is accurate and complete and that I have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that the information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy.

x_____ *(Signature of Patient/or Guardian)* _____*(date)*

x_____ *(Print name of Guardian)*