

CONFIDENTIAL

Lyndhurst Dental Centre

Our mission is to serve those who seek comprehensive dental care. Our commitment is to provide a modern facility with the latest equipment and technical skills. Our personalized service features thorough examinations, customized treatment plans and an emphasis on regular preventive care. Expect "quality care in a caring atmosphere".

Please fill in with the patient's information:

Family Name: _____ First Name & Initial: _____
Street Address: _____ City/Town: _____
Postal Code: _____ Telephones: Home _____ Work _____ Fax _____
Cell _____ E-Mail Address _____
When is it best to reach you? _____ Where is it easiest to reach you? _____
Would you be available for short notice appointments? Y N Place of work: _____
Student: Yes No If yes.....Name of School: _____
Date of Birth: Day _____ Month _____ Year _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
Emergency Contact Relationship to Patient: _____

For the safety of some of our patients who are highly allergic - please help us to maintain a peanut free - scent free ...environment - please no body scent, hair spray or cigarette smoking on day of your appt. Thank you for your co-operation!

We accept: Cash, Debit Card, Visa, Mastercard or Personal Cheque.

Without prior arrangement, payment is expected on the day of the appointment.

Our Office Team will be happy to discuss arrangements with you.

If you are unable to keep an appointment please give at least two working days notice.

Missed appointments and late cancellations may be subject to a \$60.00 fee.

Dr. McGregor recommends providing you with an estimate before starting treatment.

Person responsible for Account (if different from Patient listed above)

Name: _____ Policy Holders Date of Birth: _____
Address: _____
Relationship to Patient: _____ Home Phone: _____ Work Phone: _____

Do you have a Dental Insurance Plan? Yes No

If Yes:

Please read the accompanying letter explaining claim submission procedures.
Fill in the requested information. (Ask our Office Team, if you need assistance.)
Continue this form next page

If No:

Continue next page

We now need a fairly extensive Medical History

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Why? Does it really relate to my teeth? Yes, it is all inter-related. We especially need to know if you are taking any medications or if you have any limiting physical conditions. You can count on being asked if there is any change in your medical condition each and every time you visit the office. **It is for your health!**

Please circle yes or no, and add any information you feel might be useful.

Dr. McGregor will review your questionnaire with you.

What is the main reason for coming to our office? _____

Are you having pain or discomfort at this time?..... Yes No

Do you feel nervous about having dental treatment?..... Yes No

Have you ever had a bad experience in a dental office?..... Yes No

Have you been a patient in the hospital during the past two years?..... Yes No

Have you been under the care of a medical doctor in the past two years?..... Yes No

Have you ever had any type of surgery?..... Yes No

If yes, please list type and date of treatment. _____

Name & location of your family doctor _____

Have you taken any medicine or drugs in the past two years?..... Yes No

Please list all **prescriptions** and **over the counter medication** here: (Vitamins, Herbals etc. are to be listed on Page 3)

Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes), or have you ever reacted adversely to any of the following:

Aspirin	Codeine	Ibuprofen	Tylenol	Other pain pill not listed
Penicillin	Erythromycin	Dalacin C	Sulfa Drugs	Other antibiotics not listed
Local Anaesthetic	General Anaesthetic	IV Sedation	Nitrous Oxide (Laughing gas)	
Tranquilizers/Sedatives	Other medication not listed _____			
Latex Allergy				

Have you ever had any excessive bleeding requiring special treatment?..... Yes No

Are you taking anticoagulants or blood thinners?..... Yes No

Do you bruise easily?..... Yes No

Have you had tonsils removed?..... Yes No

Have you had adenoids removed?..... Yes No

Circle any of the following, which you have had or have at present.

Heart attack	Angina pains	Heart disease	Bypass surgery	Angioplasty
Other heart surgery	Heart murmur	Mitral valve prolapse	Pacemaker	Artificial heart valve
Rheumatic fever	Scarlet fever	High blood pressure	Congenital heart condition	
Stroke/mini stroke	Artificial joints (hip, knee....)		Asthma (inhalers _____)	
Chronic bronchitis	Cough	Emphysema	Tuberculosis	Cortisone medication
Hay fever	Sinus problems	Allergies/hives	Allergy to bee, wasp, yellow jacket stings	
Carry EpiPen Y N	Kidney disease	Liver disease	Organ transplant _____	
Ulcers	Diabetes	Oral/Injectable insulin (Ave. readings _____)		
AIDS	Hemophilia	Sickle Cell Anemia	Anemia	Yellow Jaundice
Blood transfusion	Drug addiction	Alcohol addiction	AIDS positive serum Acid Reflux	
Glaucoma (eye drops _____)	Thyroid disease (thyroid meds _____)			
Hepatitis A	Hepatitis B (serum)	Hepatitis C	Rheumatoid/Osteo arthritis	
Smoke cigarettes-how many _____	Chew tobacco-how much _____			
Cold sores	Genital herpes	Venereal disease	Yeast infection	Epilepsy or seizures
Fainting spells	Nervousness	Panic/Anxiety attacks	Psychiatric treatment	

Cancer, type _____

Radiation therapy Chemotherapy Do you attend the Cancer Clinic for follow up visits Yes No

Have you been told that you snore?..... Yes No

Have you ever had a sleep study?..... Yes No

Do you use a CPAP?..... Yes No

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Any other medical conditions not listed above: _____

Do you use recreational street drugs?.....	Yes	No
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or being very tired?.....	Yes	No
Do your ankles swell during the day?.....	Yes	No
Do you need to be elevated to sleep?.....	Yes	No
Do you ever wake from sleep with shortness of breath?.....	Yes	No
Are you pregnant?.....	Yes	No
Are you taking birth control pills?.....	Yes	No

*******Antibiotics may reduce the effectiveness of birth control pills. If these are prescribed for you, you must use an alternate method of birth control during the remainder of your cycle*******

Are you taking hormone replacement therapy?.....	Yes	No
Are you vegetarian? lacto/ovo/vegan.....	Yes	No
Are you on a special diet?.....	Yes	No
Have you ever been anorexic/bulimic?.....	Yes	No
Are you taking Vitamin, Mineral or Herbal Supplements?.....	Yes	No
If yes, please list names and dosage taken daily _____		

Is this your first visit to a dental office?.....	Yes	No
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If no, name of your previous dentist _____

What did you like/not like about that dentist? _____

What are you looking for in a dentist? _____

How did you find out about Dr. McGregor's office? _____

Who may we thank for referring you? _____

Are you having any pain in your teeth/gums?.....	Yes	No
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Do you have any clicking, popping or pain in the jaw joints?.....	Yes	No
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Is there any change in the way your teeth fit together?.....	Yes	No
--	-----	----

Is there something you would like to change/improve about your smile?.....		Yes
--	--	-----

No

What? _____

Does/did anybody in your family have gum disease?.....	Yes	No
--	-----	----

Are you worried that you may have bad breath?.....	Yes	No
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Do you brush your tongue?.....	Yes	No
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How often? _____

Do you floss your teeth?.....	Yes	No
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How often? _____

Do your gums bleed when you brush?.....	Yes	No
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Do your gums bleed if/when you floss?.....	Yes	No
--	-----	----

Are there places in between your teeth where floss gets caught or shreds?.....	Yes	No
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If yes, where? _____

Are there places in between your teeth where foods gets stuck?.....	Yes	No
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If yes, where (example, upper right back)? _____

Do you use mouthwash?.....	Yes	No
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If yes, does it contain alcohol? **Yes No Not sure**

Do you use a fluoride rinse?.....	Yes	No
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If yes, which one and how often? _____

Do you use a manual or power toothbrush?.....		
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Are you wearing any removable full or partial dentures?.....	Yes	No
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If yes, are they loose?.....	Yes	No
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are they cracked or worn?.....	Yes	No
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are they missing teeth?.....	Yes	No
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are they causing gum pain?.....	Yes	No
are they in your pocket?.....	Yes	No
How old are they/when were they made? _____		
Do you wear any type of oral appliance? (eg. retainers, night guard, splint, sleep apnea).....	Yes	No
Do you have any caps/crowns on your teeth?.....	Yes	No
Do you have any fixed bridgework?.....	Yes	No
Do you have any jaw bone retained implants?.....	Yes	No
Have you had orthodontic treatment (braces)?.....	Yes	No
Have you ever worn orthodontic appliances or retainers?.....	Yes	No
Is your "bite" comfortable?.....	Yes	No
Do you think you grind or clench your teeth?.....	Yes	No
If yes, during the day or when you are sleeping?		
Have you ever worn a nightguard or grinding appliance?.....	Yes	No
Do you play contact sports?.....	Yes	No
If yes, do you have an athletic protective mouthguard?.....	Yes	No
If yes, was it custom made for your teeth?.....	Yes	No
Did you ever sustain any facial injuries (including childhood bicycle spills, falls, blows to the face/mouth....ect.)?.....	Yes	No
Did you ever fracture a facial bone?.....	Yes	No
Did you ever have a head injury?.....	Yes	No
Do you have a chiropractor?.....	Yes	No
If yes, who?		
If yes, when is your next visit?		
Do you wear orthotics or any body supports, brace?.....	Yes	No
Have you ever had acupuncture?.....	Yes	No
Do you use a TENS system?.....	Yes	No
Have you ever been to a periodontist (gum specialist)?.....	Yes	No
If yes, which one?		
Are you still in treatment?.....	Yes	No
If yes, when is your next scheduled visit?		
Have you ever had a root canal?.....	Yes	No
Do you think your mouth reflects your overall health, or that your overall health (or lack of it) can affect the health of your teeth, gums and bite?.....	Yes	No
If you could have whatever you wished for in regard to your teeth, your Smile, you mouth etc.... what would that be?		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform Dr. McGregor or a member of her staff at the next appointment.

I acknowledge that your office has a Privacy Code and I can ask to see this Code at any time. I agree that Dr. Catherine McGregor can collect, use and disclose personal information about my dependants and myself as outlined in the previously mentioned Privacy Code.

I consent to the anonymous sharing of my clinical information for the purpose of education and discussion.

Date

Signature of patient Parent or Guardian if patient
is under 18 years or if patient is physically
or mentally unable to complete themselves.

Signature of Dentist