Scident Family Dental Clinic

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&
Associates

☐
☐

Medical Alert:

File Number:_____

Personal Information and Patient Registration

"All information is strictly confidential"

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH Y /M /D
ADDRESS			
CITY/PROVINCE			POSTAL CODE
TELEPHONE RESIDENCE:	BUSINESS:		MESSAGES:
OCCUPATION	EMPLOYER		
HOW DID YOU HEAR ABOUT THE OFFICE: (Referal Source)		E-Mail:	
PERSON RESPONSIBLE FOR THE ACOUNT IF DIFFERENT FROM ABOVE Name: Relationship:			DO YOU HAVE DENTAL INSURANCE Yes ☐ No ☐
ADDRESS IF DIFFERENT FROM ABOVE			IN CASE OF EMERGENCY, PLEASE NOTIFY Name:
EMPLOYER			Relationship: Telephone:
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT OF OUR OFFICE? YES ☐ NO ☐ RELATIONSHIP:			

Dental Insurance Status

Insurance Company #1…….
Policy Holder……Employer……..
Grp/Policy:……..…ID/Cert:……..……..

Coverage: Preventive:…… Basic:..…… Major:……..
Ortho:…… Scl/Rtpl:…..…. Endo:…… Surgical:...….

Limits: Basic:…….. Major:…..… Combined:……..
Benefit Year:……..,.. Deductable:……..

Recall Frequency:……..……
Scl:……..……..… Rtpl:……..…..… OHI:……..…….

Radiographs: Pan:……. FMS:…..… BW:…….
Exams: Spec:…… Emerg:…… Complete:……..
Composite Flgs: Molars:…… Premolars:..……
Night Guard: Basic:…... Major:..…. pre-auth:...…….

Claim Submission: Paper Y – N Electronic(EDI) Y - N
Assignment Allowed: Y……, N……

Insurance Company #2…….
Policy Holder……Employer……..
Grp/Policy:……..…ID/Cert:……..……..

Coverage: Preventive:…… Basic:..…… Major:……..
Ortho:…… Scl/Rtpl:…..…. Endo:…… Surgical:...….

Limits: Basic:…….. Major:…..… Combined:……..
Benefit Year:……..……..., Deductable:……..

Recall Frequency:……..……
Scl:……..……..… Rtpl:……..…..… OHI:……..…….

Radiographs: Pan:……. FMS:…..… BW:…….
Exams: Spec:…… Emerg:…… Complete:……..
Composite Flgs: Molars:…… Premolars:..……
Night Guard: Basic:…... Major:..…. pre-auth:...…….

Claim Submission: Paper Y – N Electronic(EDI) Y - N
Assignment Allowed: Y……, N……

MEDICAL HISTORY

MEDICAL ALERT: _____
_____
_____

NAME:_____

1. Has there been any change in your general health within the last year? .... Yes ☐ No ☐
2. Are you presently under the care of a physician? If so, for what condition? .... Yes ☐ No ☐

_____
_____

3. The name and address of your physician is: _____
_____

4. My last physical exam was on....., and in that examination was anything unusual or abnormal found?_____
_____

5.Have you ever been hospitalized or had serious illness? If yes what was the problem?.. ..... Yes ☐ No ☐
_____

6. Have you ever required a blood transfusion, If yes, what were the circumstances .... Yes ☐ No ☐
_____

7. Are you taking any medicine, drugs, or pills of any kind? If yes, What kind?.... .... Yes ☐ No ☐
_____
_____

8. Do you have any allergies? If yes, to what and how do you react? .... Yes ☐ No ☐
_____
_____

9. Have you ever had an unusal reaction to a dental anesthesia? .... Yes ☐ No ☐
_____

10. Have you ever had abnormal bleeding associated with surgery, injuries, or extractions? ..... Yes ☐ No ☐
_____

11. Have you ever had any known contact with the AIDS virus? .... Yes ☐ No ☐
12. Has any member of your family had diabetes? .... Yes ☐ No ☐
13. Have you ever fainted .... Yes ☐ No ☐

14. Are you pregnant? If so which month are you in? _____ .... Yes ☐ No ☐
15. Are you taking any birth control pills? .... Yes ☐ No ☐
16. Are you breast feeding? .... Yes ☐ No ☐

17. Do you have or have you ever had any of the following disorders? [Please check √]

Rheumatic heart disease	☐	Stomach/intestine problems	☐
Rheumatic fever	☐	Tuberculosis	☐
Congenital heart disease	☐	Asthma	☐
Coronary artery angina	☐	Lung disease	☐
Heart attack	☐	Venereal disease	☐
Stroke	☐	Positive testing for HIV virus	☐
High blood pressure	☐	Blood disorder	☐
Heart murmur	☐	Hepatitis A/B	☐
Diabetes (sugar disease)	☐	Epilepsy or seizures	☐
Kidney disease	☐	Sinus trouble	☐
Liver disease	☐	Drug addiction	☐
Thyroid disease	☐	Mental or nervous disorders	☐
Cortisone/steroid therapy	☐	Herpes/cold sores	☐
Severe headaches	☐	Cancer	☐
Dizziness or fainting	☐	Ear problem	☐
Bruise easily	☐	Eye problem	☐
Sore throat	☐	Nose bleeds	☐
Frequent colds	☐	Chest pain on exertion	☐
Swollen ankles	☐	Speech problem	☐
Shortness of breath	☐	Others	☐

18. Have you ever had radiation treatment or chemotherapy?..... ..... Yes ☐ No ☐
19. Have you had organ transplants or medical implants?..... ..... Yes ☐ No ☐

20. Do you consider yourself a healthy individual..... ..... Yes ☐ No ☐
21. Is there any disease or problem not listed above?..... ..... Yes ☐ No ☐

22. Vital signs Blood Pressure_____ Pulse_____ Respiration_____ .... Temperature_____

DENTAL HISTORY

1. Chief dental complaint _____
2. Reason for today's appointment: Consult☐ Exam☐ Cleaning☐ Emergency☐ Others☐
3. How often do you see a dentist?_____Date of last visit _____Reason _____
4. Name of your former dentist _____ Telephone: _____
5. Date of last cleaning_____ ..... Date of last full mouth x-ray_____

Dental Hygiene

5. Have you ever had proper oral hygiene instruction Yes .....☐ No ☐
6. Do you brush? Yes ☐ No☐ How often? 1**X**day☐ 2**X**day☐ 3**X**day☐ 2**X**week ☐.. Other
7. What kind of brush do you use? Soft☐ Medium☐ Hard☐ Others _____
8. Do you floss? Yes ☐ No☐ How often? 1**X**day☐ 2**X**day☐ 3**X**day☐ 2**X**week ☐Other_____
9. What kind of floss do you use? Waxed☐ Unwaxed☐ Tape☐ Others _____
10. Does your gum bleed, when you Brush ☐ Floss☐ Spontaneous☐

Teeth and Occlusion

11. Is/Are your tooth/teeth sensitive to Cold ☐ Heat☐ Sweets☐ Others_____
12. Do you chew on one side of your mouth Yes☐ No☐ Right side☐ Left side☐
13. Are you aware of grinding your teeth at night or day time ..... Yes ☐ No☐
14. Does your jaw click or crack or pop when you chew or open widely? ..... Yes ☐ No ☐

15. Please check (√), if you now have or ever had any of the following conditions/treatments in your mouth:

Broken or lost fillings	☐	Root canal fillings	☐	Partial dentures	☐
Extraction	☐	Gum Surgery	☐	Complete dentures	☐
Loose teeth	☐	Bridges	☐	Dental implants	☐
Swelling	☐	Crowns/Caps	☐	Orthodontic treatment	☐
Bad Breath	☐	Bleeding from gum	☐	Bleaching	☐

16. How would you rate your current oral health: Excellent☐ Good☐ Fair☐ Poor☐

Treatment Authorization & Consent

I, the undersigned, certify that all information provided in this chart is true and I have not deliberately withheld any information, if it is necessary for my dental health, I authorize the dentist to contact my physician for confirming the medical information. I also consent to the dental treatments including surgical procedures agreed to be necessary or beneficial for my dental condition and will assume responsibility for fees associated with these procedures.

Patient [Parents, Guardian] Signature _____

Date_____

To avoid complications, it is important to inform the office of any changes in your medical conditions.