SIERRA DENTAL

Name First : _____ Last _____ DOB: _____ /_____ /_____

Address:_____ City : _____

Province : _____ Postal Code : _____

Primary Phone Number : (_____)- _____ – _____ Secondary Phone Number : (_____)- _____ – _____

Emergency Contact : _____ Emergency Number : (_____)- _____ – _____

Referred By : _____

Not referred? ☐ How did you find us? _____

Insurance Plan 1:

Subscriber Name : _____ Birth Date : _____ /_____ /_____

Company Name : _____

Insurance Company : _____ Group Policy Number : _____

Subscriber ID : _____

Insurance Plan (Secondary):

Subscriber Name : _____ Birth Date : _____ /_____ /_____

Company Name : _____

Insurance Company : _____ Group Policy Number : _____

Subscriber ID : _____

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SIERRA DENTAL

Medical Profile

1) Medical Physician:

_____

2) Medical Physician Telephone (if known): (_____)- _____ – _____

3) Date of Last Visit to Physician:

_____

4) Medical Specialist:

_____

5) Medical Specialist Telephone (if known): (_____)- _____ – _____

6) Date of last visit to Medical Specialist:

_____

7) Do you believe you are in good health? If no, explain N☐ Y☐

8) Describe any notable changes in the past 2 years.

_____

9) Describe any reasons why you have been hospitalized in the last 2 years.

_____

10) Have antibiotics ever been suggested prior to dentistry? N☐ Y☐

11) List any medications you are currently taking either on your own (over the counter) or prescribed by your doctor.

_____

_____

12) Have you taken any cortisteroids in the last six months? N☐ Y☐

13) Have you ever had any allergic or adverse reaction to any medication or drug including anesthetic? N☐ Y☐

14) Are you allergic to latex, plastic bandages or metal? N☐ Y☐

15) List any other allergies:

_____

_____

16) Describe any special dietary needs:

_____

17) If female, are you currently taking birth control pills? N☐ Y☐

18) Is there a chance that you may be pregnant? N☐ Y☐

19) If YES, please specify your due date:_____/_____/_____

20) Please describe anything else we can do to make your appointments more comfortable.

_____

_____

In each of the following, please check off any symptom that describes your current medical profile and history. (√) check mark indicates "YES")

Severe Headaches	☐	Migraine Headaches	☐
Fainting	☐	Dizzy Spells	☐
Epilepsy or seizures	☐	Nervousness	☐
Psychiatric Disorder	☐	Eating Disorder	☐
Sensory / Communication Disorder			☐
Learning or behavioral disorder			☐
Skin rashes	☐	Skin Cancer	☐
Arthritis	☐	Artificial Joints	☐
Sore Muscles	☐	Night Sweats	☐
Osteoporosis	☐		
Heart Disease	☐	Heart Attack : when? ____/____/_____	
Heart Failure	☐	Swollen Ankles	☐
Angina	☐	Heart Murmur	☐
Artificial Valve	☐	Rheumatic fever	☐
Pacemaker	☐	Stroke	☐
Aneurysm	☐		
Congenital heart defect			☐
Mitral Valve Prolapse			☐
Heart surgery or transplant			☐
High/Low blood pressure (last reading) _____			☐
Easy bruising	☐	Bleeding tendency	☐
Anemia	☐	Sickle Cell disease	☐
Hemophilia	☐	Leukemia	☐
Blood Transfusion or products			☐
Seasonal Allergies	☐	Hay Fever	☐
Sinus Problems	☐	Asthma	☐
Chronic cough	☐	Shortness of Breath	☐
Emphysema	☐	Cystic fibrosis	☐
Tuberculosis	☐		
Diabetes	☐	Thyroid disease	☐
Hodgkin's disease	☐	Glandular disorder	☐
Jaundice	☐	Bladder Problems	☐
Kidney Problems	☐	Kidney transplant	☐
HIV infection	☐	Urinary infection	☐
Sexually Transmitted disease			☐
AIDS or AIDS-related diseases			☐
Ulcers	☐	Bowel disease	☐
Persistent diarrhea	☐	Hepatitis	☐ Type: _____
Liver disease	☐	Cirrhosis	☐
Use tobacco	☐	Use alcohol	☐
Organ transplant	☐	Tumor or cancer	☐
Radiation therapy	☐	Chemotherapy	☐

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Dental Profile

1) Are you answering these questions for a child or ward? N☐ Y☐

2) If so, does your child clean his/her own teeth? N☐ Y☐

3) What has prompted your visit to our office today?
_____

4) When was your last dental hygiene visit?
_____

5) How frequently do you normally visit a dental office?
_____

6) How recently have you had dental x-rays taken?
_____

7) Name of previous dentist:
_____

8) Do you frequently eat or drink foods with high sugar content? N☐ Y☐

9) Have you had neck or shoulder aches? N☐ Y☐

10) Have you ever had difficulty opening or closing your mouth? N☐ Y☐

11) Have you ever had clicking or popping sounds in your jaw? N☐ Y☐

12) Do you wake up with soreness in your face or neck muscles? N☐ Y☐

13) Do you feel like you grind or clench your teeth? N☐ Y☐

14) Do you favor one side of your mouth when you eat? N☐ Y☐

15) Does your jaw get sore during or after dental treatment? N☐ Y☐

16) Have you ever experienced any injuries to your face or jaw? N☐ Y☐

17) Do you wear a splint when you sleep or during the day? N☐ Y☐

18) Do you regularly get food caught between your teeth? N☐ Y☐

19) Do you suffer frequently from canker or cold sores? N☐ Y☐

20) Do you suffer from dryness of the mouth? N☐ Y☐

21) Do any of the following habits apply to you: *(please specify below)*
☐ Lip or Nail biting ☐ chewing or holding objects in your mouth
☐ Mouth Breathing ☐ Other? _____

22) Do you ever have burning sensations in your lips or tongue? N☐ Y☐

23) Have your gums ever been swollen or tender? N☐ Y☐

24) Do you feel that you have bad breath at times? N☐ Y☐

25) Do your gums bleed when brushing, chewing or flossing? N☐ Y☐

26) Are your teeth ever sensitive to cold or sweetness? N☐ Y☐

27) Are your teeth sensitive to heat or pressure? N☐ Y☐

28) When bending down, do your teeth hurt? N☐ Y☐

29) Have you noticed any movement in your teeth? N☐ Y☐

30) Have you had a bump or swelling on your gums? N☐ Y☐

31) A dentist has adjusted the way your teeth come together N☐ Y☐

32) Have you ever had treatment for gum disease? N☐ Y☐

33) If yes, would you like to learn about alternative treatments to help prevent further disease progression? N☐ Y☐

34) On a scale of 1-10, rate the appearance of your smile : _____

35) On a scale of 1-10, rate where you would like your smile:_____

36) Is there anything you would like to change about your smile? N☐ Y☐

37) Would you like a whiter smile? N☐ Y☐

38) Have you ever had braces? N☐ Y☐

39) If so, do you wear retainers? N☐ Y☐

40) Interested in straightening your teeth or correcting your bite? N☐ Y☐

41) Do you feel nervous about being at the dentist? N☐ Y☐

42) If so, on a scale of 1-10, how nervous do you feel? _____

43) Do you have a bad gag reflex? N☐ Y☐

44) Would you like to know more about options to relax you during dental or hygiene treatment? N☐ Y☐

45) Do you have missing teeth? N☐ Y☐

46) If so, would you like to know options to replace them? N☐ Y☐

47) Do you wear a partial or full denture? N☐ Y☐

48) Is it full or partial? _____

49) Are you happy with how your denture fits? N☐ Y☐

50) How old are your current dentures? _____

51) Would you like your denture adjusted or relined? N☐ Y☐

52) Do you still have your wisdom teeth? N☐ Y☐

53) Do you play sports that could cause injury to your teeth? N☐ Y☐

54) Do you participate in high performance sports? N☐ Y☐

55) Do you often feel tired during the day? N☐ Y☐

56) Do you have a general lack of energy? N☐ Y☐

57) Do you snore? N☐ Y☐

58) Have you ever been diagnosed with sleep apnea? N☐ Y☐

59) Do you have any particular concerns or preferences that we should be aware of regarding your dental care and treatment?
_____
_____

60) Are there any aspects of dentistry that you would like to hear more about?
_____
_____

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