Gateway Dental Clinic

Dr. Marc Noderer

Patient Information

A parent or guardian will be responsible or decisions on my treatment __ yes __no

Name: First_____ Middle Initial_____ Last name _____ Preferred Name_____

Female __ Male__ Care Card Number: _____

Address: Street_____ Apt_____

City_____ Prov_____ Postal code_____

Date of birth: Month/Day/Year Email:_____

Home PH: (___)_____ Work PH: (___) _____ Cell PH(___) _____

Emergency Contact: Name:_____ Relation to you_____

PH: _____

Family Doctor: _____ PH (____) _____

Whom may we thank for referring you? _____

Financial Information

Method of payment: ___cash ___cheque ___credit card ___insurance ___other
Person Responsible: ____self ___spouse ___ parent /guardian ___other

Insurance:

Primary Insurance:

Policy Holder: _____ DOB (M/D/Y): ___ /___ /_____

Insurance Company: _____ Employer: _____

Policy #: _____ID#: _____ Status # _____

Max Coverage:_____ Basic % :_____ Major %: _____ Deductible:_____

Secondary Insurance:

Policy Holder: _____ DOB (M/D/Y): ___ /___ /_____

Insurance Company: _____ Employer: _____

Policy #: _____ID#: _____ Status # _____

Max Coverage:_____ Basic % :_____ Major %: _____ Deductible:_____

Dental History:

1: What is the reason for today's visit? ___Emergency ___Examination ___Consultation ___Other

2: How frequently do you see a dentist? ___3-6 months ___Annually ___Other

3: When was your last dental visit? _____ Last X-rays? _____

4: How often do you brush per day ____ Floss? _____ Mouth Rinse? _____

5: Are your teeth sensitive to: ___ Cold ___ Sweets ___Heat ___Other

6: Do your gums bleed when: ___Brushing ___ Flossing ___ Never

7: Do your gums feel swollen or tender?..... __Yes __No

8: Do you have bad breath or a bad taste in your mouth ..... __Yes __No

9: Does your jaw crack, pop, or grate when you open widely?..... __Yes __No

10: Do you grind or clench your teeth?..... __Yes __No

11: Does food catch between your teeth?..... __Yes __No

12: Have you ever had local anaesthetic (freezing)?..... __Yes __No

Any complication? ___ Yes ____ No If Yes Please Specify_____

13: Have you ever had any problems with previous dental treatment?..... __Yes __No

If Yes, Please Specify: _____

14: Have you ever had any of the following? __Bridgework __Crowns __Dentures __Orthodontics

__Root canal __Periodontal (gums)

15: Are you satisfied with your teeth?..... __Yes __No

If No, Please Specify_____

Medical History:

1: Are you presently under the care of a physician? ..... __Yes __No

If Yes, Please Specify: _____

2: Have you ever been hospitalized? ..... __Yes __No

If Yes, Please Specify: _____

3: List any prescriptions or non-prescription medicine you take regularly:

1)Drug _____ Reason _____

2)Drug _____ Reason _____

3)Drug _____ Reason _____

4: Have you ever had any adverse effects to any of the following?

__ Antibiotics __ Sulfonamide __ Codeine
__ Aspirin __ Barbiturates (Sleeping Pills) __ Other _____
__ Ibuprofen __ Local Anaesthetic __ None

5: Have you ever been warned against using any other medications: …….. __Yes __No

6: Have you ever taken prolonged medical or non- medical drugs: …….. __Yes __No

Please specify: _____

7: Do you suffer from any allergies (hay fever, latex, etc.) …….. __Yes __No

8: Do you bruise easily or have prolonged bleeding? …….. __Yes __No

9: Do you smoke? How much per day? …….. __Yes __No

10: Have you ever had any of the following: __fainted __shortness of breath __chest pain?

When was the episode? _____

11: **WOMEN:** Are you pregnant? __ Yes __ No
Using birth control? __Yes __ No
Reached menopause? __ Yes __ No

12: Do you have any of the following?

__ AIDS	__ Epilepsy or Seizures	__ Lung disease
__ Anemia	__ Glandular disorder	__ Malignant hyperthermia
__ Angina Pectoris	__ Glaucoma	__ Mental/ nervous disorder
__ Anorexia Nervosa	__ Head / Neck injury	__ Mitral Valve Prolapse
__ Arthritis / Rheumatism	__ Heart Disease / Attack	__ Organ Transplant/ Implant
__ Artificial Heart Valve	__ Heart Murmur	__ Psychiatric Treatment
__ Artificial Joints (knee, Hip)	__ Heart Pacemaker/ Surgery	__Radiation / Chemotherapy
__ Asthma	__ Heart Rhythm Disorder	__ Rheumatic / Scarlet Fever
__ Blood Disorders	__ Hepatitis A,B,C	__ Sickle Cell Disease
__ Bronchitis	__ Herpes	__ Sinus Trouble
__ Bulimia	__ High / Low Blood Pressure	__ Stomach / Intestinal Problems
__ Cancer	__ HIV Positive	__ Stroke
__ Circulation Problems	__ Hodgkins Disease	__ Thyroid Disease
__ Congenital Heart Legion	__ Hyper (Hypo) Glycemia	__ Tuberculosis
__ Cortisone / Steroid	__ Hypertension	__ Ulcers
__ Diabetes	__ Jaundice	__ Venereal Disease
__ Drug/ Alcohol dependence	__ Kidney Disease	__ Other_____
__ Emphysema	__ Liver Disease	__ None

13: Have you had a recent illness? __ Yes __ No

When?_____ Specify illness: _____

By signing this document I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other procedures as may be required to determine necessary treatment. Understand that it is my responsibility to pay for dental treatment for both myself, and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature __ Self __ Parent / Guardian Print Name Date