Oakville Lane Dental

Dr. Aaron Tait Dr. Ron Buckley Dr. Janet Bailey

Name _____ Date of Birth _____

Dental Plan _____ Address _____

Postal Code _____ Phone _____ Work _____Cell _____

Family Doctor_____ Occupation _____

Referred By _____

Questionnaire

1. What is your current dental problem? _____ Last dental appointment? _____
2. What is your main dental concern? _____
3. If you could, what would you change about your teeth? Colour/Position/Shape? _____
4. Do you floss? Yes/No How often? _____
5. Coffee/Tea/Pop drinker? How often? _____
6. Do you smoke? Yes/No How often? How long? _____
7. Do you get Canker Sores/Cold Sores? How often? _____
8. Do you have any oral habits? Nail Biting/Thumb Sucking/Pen Chewing? _____
9. Do you Clench/Grind your teeth? Do you have pain in your jaw? Headaches? Explain: _____

_____

Medical Questionnaire

1. Have you had any reactions to drugs or medicines? To what? Explain: _____
2. Do you have any allergies? ie penicillin/latex? _____
3. Is your physician treating you for any current conditions? _____
4. What medication if any are you taking now? _____
5. Have you taken cortisone or steroids? _____
6. Have you had any major operations or been hospitalized in the last 6 months? _____
7. Do you have any of the following? PLEASE CIRCLE

Abnormal Bleeding Shortness of Breath Asthma Heart Murmur Heart Disease High Blood Pressure Extreme loss/gained Weight

Tumors/growths Hepatitis A/B/C Blood Disorders/Anemia Radiation Therapy Chemotherapy Epilepsy Diabetes Type I/II

Rheumatic Fever Thyroid trouble Kidney trouble Tuberculosis

8. Have you tested positive for any Venereal Diseases? Yes/No _____

General Release

I, the undersigned, confirm that all information given is true. I consent to the performing of the dental/surgical procedures as agreed or advised to be necessary; this includes the use of local anesthetic /nitrous sedation. I assume the responsibility of all fees associated with those procedures.

Third party involvement (dental insurance) will be submitted as a courtesy to you. Your portion of coverage is payable at the time of your appointment, any changes in your coverage at the time of billing is your esponsibility. Dental Insurance is arranged between you and your employer; we do not have access to individual policies/ coverage.All information is held in confidence in accordance of the Privacy Act.

(signature) Parent/Patient/Guardian _____

(please print name) _____