Falls Family Dental New Patient Information

Welcome and thank you for choosing Falls Family Dental! To ensure we have the information needed to serve you best, please complete the form below. As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please do not hesitate to ask a member of our team if you have any questions about this form.

Today's date (dd/mm/yy): _____

First name: _____ **Last name**: _____

Home phone number: _____ Work/cell phone number: _____

Email address: _____ Would you like to receive text message reminders? Yes No

Address: _____
Street # Street Name Apt # City Postal Code

Date of birth: _____ Gender: _____ Height/Weight:_____
(dd/mm/yy)

If you are completing this form for another person:

Your name: _____ Relationship to Patient: _____

Emergency Contact Information:

Full Name: _____ Relationship to that person: _____

Contact Information: _____

Who do we thank for your referral? Please check/fill all that apply

Referred by another patient: _____ Staff member/doctor: _____
Patient/family name Staff member/doctor name

Friend: _____ Our website: _____ Facebook: _____ Instagram: _____ Referral from health professional: _____

Billboard: _____ Drive-By/Walk-In: _____ Other _____

Insurance Information

Name of insurance company: _____ Employer: _____

Name of policy holder: _____ Policy holder's date of birth: _____
(dd/mm/yy)

Policy number: _____ I.D. number: _____

Your relationship to the policy holder (i.e. Self, spouse, father/mother, etc.): _____

Dental Information (Please answer/circle the following questions)

Date of your last dental exam? _____

Date of last dental X-ray? _____

Do your gums bleed when you brush or floss?	Yes	No	Not sure
Are your teeth sensitive to hot, cold, sweets, or pressure?	Yes	No	Not sure
Does food or floss catch between your teeth?	Yes	No	Not sure
Is your mouth dry or difficulty swallowing?	Yes	No	Not sure
Have you had any periodontal (gum) treatments?	Yes	No	Not sure
Have you had orthodontic (braces) treatment?	Yes	No	Not sure
Have you had any problems associated with previous dental treatment?	Yes	No	Not sure
Do you snore or have sleep apnea?	Yes	No	Not sure
Are you currently experiencing dental pain or discomfort?	Yes	No	Not sure
Do you have any neck pain or earaches?	Yes	No	Not sure
Do you have any clicking, popping, or discomfort of the jaw?	Yes	No	Not sure
Have you ever had any serious injury or surgery to your head, neck, or jaw/mouth?	Yes	No	Not sure
Do you grind your teeth?	Yes	No	Not sure
Do you bite your lips/cheeks frequently?	Yes	No	Not sure
Have you ever had any growths, lumps, or sore spots in your mouth?	Yes	No	Not sure
Have you noticed any loosening/movement of your teeth?	Yes	No	Not sure
Do you wear full or partial dentures?	Yes	No	Not sure
Do you participate in physically active recreational activities?	Yes	No	Not sure
Are you nervous/anxious/fearful during dental treatment?	Yes	No	Not sure

Please list any other information that you feel we should have to provide you with the best possible dental care:

_____

_____

Medical Information (Please answer/circle the following questions)

Medical Physician name: _____ Area of Speciality: _____ Phone number: _____

Are you currently being treated for any medical condition or have you been treated within the past year? Yes No Not sure
If yes, please explain?

_____

When was your last medical checkup? _____

Were any problems identified? If yes, please explain.

_____

Has there been any change in your general health or weight in the past year? Yes No Not sure
If yes, please explain.

_____

Are you taking any medication, non-prescription drugs or herbal supplements of any kind? Yes No Not sure
If yes, please list them.

_____

Do you have any allergies? If yes, please list them using the categories below: Yes No Not sure

a) Medications _____
b) Latex/rubber products _____
c) Other (e.g. hay fever, seasonal environmental/foods) _____

Have you ever had an adverse reaction to any dental materials, injections or local anaesthetic? Yes No Not sure
If yes, please explain.

_____

Have you had a serious illness, medical condition operation, or been hospitalized in the last 5 years? Yes No Not Sure
If yes, please explain.

_____

Do you have or have you ever had a replacement or a repair of a heart valve, an infection of the heart, a heart condition from birth, or a heart transplant? Yes No Not Sure
If yes, please explain.

_____

Have you been advised to take pre-medication (e.g. antibiotics) prior to dental treatment? Yes No Not Sure
If yes, please provide details.

_____

Do you have or have you ever had any of the following? Please check.

☐ chest pain/angina rheumatic fever
☐ heart attack
☐ stroke/TIA
☐ heart murmur
☐ fainting/dizzy spells
☐ eating disorder
☐ asthma/emphysema
☐ circulatory problems
☐ rheumatic fever
☐ mitral valve prolapse
☐ tuberculosis
☐ cancer
☐ pacemaker
☐ lung disease
☐ hyper/hypoglycemia
☐ stomach ulcers
☐ high blood pressure
☐ low blood pressure
☐ arthritis/rheumatism
☐ steroid therapy
☐ diabetes
☐ mental or nervous disorder
☐ thyroid disease
☐ drug/alcohol/cannabis use or dependency
☐ seizures/epilepsy
☐ kidney disease
☐ shortness of breath
☐ osteoporosis medications (e.g. Fosamax, Actonel)
☐ other communicable disease/transmissible infection

Are there any conditions or diseases not listed above that you have or have had? Yes No Not Sure
If yes, please explain.

_____

Do you have or have you ever had any heart or blood pressure problems? Yes No Not Sure
Do you have a prosthetic or artificial joint? Yes No Not Sure
Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infections, radiotherapy, chemotherapy)? Yes No Not Sure
Have you ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders? Yes No Not Sure
Do you have a bleeding problem, bleeding disorder, bruising tendency, or have had a blood transfusion? Yes No Not Sure
If yes, please explain.

_____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) Yes No Not Sure
Do you smoke, vape, use e-cigarettes or chew tobacco products? Yes No Not Sure
Do you identify as a patient with a disability? Yes No Not Sure
If yes, please explain.

_____

Women only: Are you breastfeeding or pregnant? Yes No Not Sure
If pregnant, what is the expected delivery date? _____

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Reviewed By Dentist: _____ Date: _____

Dentist's Notes: