WELCOME TO STONEY CREEK DENTAL

Date _____

Patient's Name: Last , Frist _____ Name of Guardian: _____

Address: Street , Apt # , City , Postal Code _____ Date of Birth: _____

Cellphone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact: Name and Phone Number _____ Family Physician: Name and Phone Number _____

Are you under the care of a Medical Specialist? No ☐ Yes ☐ Name of Doctor and Phone Number _____

Primary INS Policy Holder Name _____ Policy/Group # _____ Subscriber/ID # _____

Secondary INS Policy Holder Name _____ Policy/Group # _____ Subscriber/ID # _____

DENTAL HISTORY

(If unsure of a question, please skip and discuss with the dentist)

Is there a dental problem you would like treated immediately? Yes ☐ No ☐ Date of last dental cleaning: _____

	YES	NO
1. Have you been seeing a dentist regularly?	☐	☐
2. Have you ever had any of the following:		
• Periodontal treatment (treatment of the gums)	☐	☐
• Orthodontic treatment (to straighten or realign teeth)	☐	☐
• A bite plate or any other appliance?	☐	☐
• Your bite adjusted or teeth ground?	☐	☐
• Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints)	☐	☐
If you answered 'Yes' to the last question, who performed the surgery? _____ When? _____		
Are you being followed up by a dental specialist?	☐	☐
3. Are there any growths or sore spots in your mouth?	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?	☐	☐
5. Have you noticed any loose teeth, or, have any of your teeth shifted?	☐	☐
6. Does food catch between your teeth?	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐	☐
8. Have you been advised to take antibiotics before a dental appointment?	☐	☐
9. Do you use dental floss, proxabrush or stimudents? How often? _____ How often do you brush your teeth? _____	☐	☐
10. Have you ever experienced any of the following jaw problems:		
• Popping/clicking in your jaw joints?	☐	☐
• Pain in your jaw joints, around your ear, or side of your face?	☐	☐
• Difficulty in opening or closing?	☐	☐
• Pain when teeth are clenched?	☐	☐
• Pain or difficulty while chewing?	☐	☐
11. Do you have any of the following habits:		
• Clenching or grinding your teeth while awake or asleep?	☐	☐
• Biting your cheeks or lips?	☐	☐
• Mouth breathing while awake or asleep?	☐	☐
• Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)?	☐	☐
12. Do you have any emotional concerns about having dental treatment?	☐	☐
13. Are you dissatisfied with the appearance of your teeth?	☐	☐
or, What would you like to see changed? _____		
14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____	☐	☐

(Complete both pages before signing)

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office**. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____

☐ Patient ☐ Parent ☐ Guardian

Print name of Guardian

STONEY·CREEK DENTAL

HEALTH HISTORY

Please check YES or NO to each question. If unsure of a question, then skip and consult with the dentist.

	YES	NO
1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____	☐	☐
2. Have you been hospitalized in the past 2 years? _____	☐	☐
3. When was your last visit to a Physician? _____ Last complete physical examination? _____		
4. Have you recently, or are you presently, taking any prescription or non-prescription drugs incl. herbal remedies. If yes, please list: _____	☐	☐
5. Have you ever reacted adversely to any medications or injections? If yes, please indicate and/or list: _____	☐	☐
6. Have you ever been advised against taking any specific type of medication? _____	☐	☐
7. Do you have any allergies? If yes, please indicate and/or list: _____	☐	☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If yes, please explain: _____	☐	☐
9. Is there a family history of Diabetes, Cancer or Heart Disease? _____	☐	☐
10. Do you bleed EXCESSIVELY for a cut or injury, or bruise easily? _____	☐	☐
11. Do you ankles, feet or hands swell? _____	☐	☐
12. Has your weight, appetite or energy level changed dramatically recently? _____	☐	☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____	☐	☐
14. Have you tested HIV positive? _____	☐	☐
15. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____	☐	☐
16. Have you ever had any injury or surgery to your face or jaws? _____	☐	☐
17. Do you wear eyeglasses or contact lenses? _____	☐	☐
18. Do you have any hearing difficulties? _____	☐	☐
19. Do you smoke or use any other forms of tobacco or cannabis? _____	☐	☐
20. Are you alcohol and/or drug dependent? _____	☐	☐

21. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO		YES	NO
A.I.D.S.	☐	☐	Glaucoma	☐	☐	Malignant hyperthermia	☐	☐
Anemia	☐	☐	Head/neck injuries	☐	☐	Mental/nervous disorder	☐	☐
Angina pectoris	☐	☐	Heart disease or attack	☐	☐	Mitral valve prolapse	☐	☐
Arthritis/rheumatism	☐	☐	Heart murmur	☐	☐	Organ transplant/medical implant	☐	☐
Artificial heart valve	☐	☐	Heart pacemaker	☐	☐	Psychiatric treatment	☐	☐
Artificial joints (hip, knee)	☐	☐	Heart rhythm disorder	☐	☐	Radiation treatment/chemotherapy	☐	☐
Blood disorders	☐	☐	Heart surgery	☐	☐	Scarlet fever → Rheumatic fever	☐	☐
Bronchitis	☐	☐	Hepatitis A B C	☐	☐	Sickle cell disease	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Sinus trouble	☐	☐
Circulation problems	☐	☐	High/low blood pressure	☐	☐	Stomach/intestinal problems/Ulcers	☐	☐
Congenital heart lesions	☐	☐	Hodgkin's disease	☐	☐	Stroke	☐	☐
Cortisone/steroid	☐	☐	Hyper/Hypo Glycemia	☐	☐	Thyroid disease	☐	☐
Crohn's disease	☐	☐	Hypertension	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Inflammatory bowel disease	☐	☐	Venereal disease	☐	☐
Emphysema	☐	☐	Jaundice	☐	☐			
Epilepsy or seizures	☐	☐	Kidney disease	☐	☐	COVID-19	☐	☐
Fainting or dizzy spells	☐	☐	Liver disease	☐	☐			
Glandular disorders	☐	☐	Lung disease	☐	☐	Other _____		
			Lupus	☐	☐	Other _____		

23. Has the CHILD PATIENT recently had any of the following (indicate approximate date):

☐ Measles _____ ☐ Strep throat _____
☐ Mumps _____ ☐ Tonsillitis _____
☐ Chicken Pox _____

24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? If yes, please explain: _____	☐	☐

25. Is there anything else about your health we should be made aware of? _____
26. Do you wish to speak privately to the Doctor about any problem or medical condition? Y ☐ N ☐
27. Are you pregnant or suspect you may be? Y ☐ N ☐ Expected delivery date? _____
28. Are you taking any birth control pills? Y ☐ N ☐ Are you breastfeeding? Y ☐ N ☐

Note: It is important that any change in your health status be reported to our office.

Reviewed by Dentist: _____ STONEY·CREEK DENTAL Date of Review: _____