PROSTHODONTICS
on chamberlain

Fill out this PDF form electronically, then print it out
OR print the form out and fill it in by hand.
Please submit the completed form in person.
Please do not submit your form by email.

TODAY'S DATE: Day Month Year

Your cooperation in completing this questionnaire is essential in establishing a basis for comprehensive dental treatment. All information is confidential.

GENERAL INFORMATION

FULL NAME: ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss.** ☐ **Dr.**

ADDRESS:

CITY/POSTAL CODE: EMAIL:

HOME PHONE: BUSINESS PHONE: CELL PHONE:

OCCUPATION: EMPLOYER:

DATE of BIRTH: **Day** **Month** **Year**

DENTAL INSURANCE: Policy #: ins. I.D.#:

Is insurance through your spouse? ☐ no (skip Spouse info) ☐ yes, primary ☐ yes, secondary

SPOUSE'S NAME

DATE of BIRTH: **Day** **Month** **Year**

DENTAL INSURANCE: Policy #: ins. I.D.#:

Family Physician: Address:

Phone: Date of last medical examination:

In Case of Emergency, please allow us to contact:

Phone: Relationship:

MEDICAL HISTORY

1. All MEDICATIONS currently taking? (Please include dosages, if possible)

2. Any Adverse Reaction to MEDICATIONS? (such as Penicillin, Sulpha drugs, Aspirin, Codeine, Local Anesthetics,...)

3. Recent HOSPITALIZATION and/or SERIOUS ILLNESS?

4. Do you have any ALLERGIC Conditions (such as Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies,...)

5. Drug or Alcohol dependency?

6. Do you SMOKE? ☐ yes ☐ no If so, how much?

7. Please indicate which of the following you presently have or ever had:

A.I.D.S. / HIV	yes	no	CANCER / CHEMOTHERAPY	yes	no	HIGH / LOW BLOOD PRESSURE	yes	no
ANEMIA	yes	no	DIABETES	yes	no	HORMONE DISORDER	yes	no
ARTHRITIS	yes	no	HEAD / NECK INJURY	yes	no	KIDNEY DISEASE	yes	no
ARTIFICIAL HEART VALVE	yes	no	HEART DISEASE	yes	no	LIVER DISEASE	yes	no
ARTIFICIAL JOINTS	yes	no	HEART PACEMAKER	yes	no	OSTEOPOROSIS	yes	no
ASTHMA	yes	no	HEART VALVE MURMUR	yes	no	PSYCHIATRIC DISORDER	yes	no
BLEEDING DISORDERS	yes	no	HEPATITIS	yes	no	SEIZURES (EPILEPSY)	yes	no

Additional Comments:

MEDICAL HISTORY (continued)

8. WOMEN ONLY: Are you PREGNANT or suspect you may be? yes no
   Are you taking birth control pills? yes no
   Are you taking supplementary hormones, please indicate: yes no

DENTAL HISTORY

Please indicate WHO referred you to this practice:

Who is your GENERAL DENTIST that you see on a regular basis:

1. DESCRIBE in your own words your MAIN CONCERN for improving your dental health?
   (i.e. Improved smile, Better chewing ability, whiter teeth,...)

	Comments	yes	no
2. Do you have any DISCOMFORT relating to your teeth?			
3. Do you have any difficulty CHEWING?			
4. Are there any sore spots or growths in your mouth or tongue?			
5. Have you ever experienced any of the following JAW problems:			
Popping/clicking in your jaw-joints?			
Pain in your jaw-joints, ears, or side of face?			
Difficulty in opening or closing?			
Clenching or grinding your teeth while awake or during sleep?			
Frequent headaches			
6. If you are wearing partial or complete DENTURES:			
WHEN were they made? Upper / Lower			
Do you have any DIFFICULTIES with your dentures?			
Do you wear the dentures at NIGHT?			
7. Are you satisfied with the APPEARANCE of your teeth or smile?			
Are you pleased with the COLOUR of your teeth?			
8. Do you suffer from dry mouth problems?			

9. ADDITIONAL COMMENTS CONCERNING YOUR DENTAL HISTORY

THANK YOU for the completion of this form. In addition, PLEASE read the following:

I, the undersigned, certify that I have provided an accurate and complete personal medical-dental history and knowingly have not omitted any information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental therapy. I also understand that consultation with my medical doctor or other dental practitioners may be required and I consent to their approach for consultation. I will also undertake responsibility for payment of the dental services as they are performed during each appointment.

SIGNATURE: DATE:

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