BROADVIEW DENTAL CLINIC
Dr. Peter Ioannidis & Dr. Renu Varshney

Chart #________________________

PERSONAL INFORMATION

Mr/Mrs/Ms/Miss/Dr/Other ____________ First Name _______________________ Last Name ____

Preferred Name ___________________________________ Pronoun Used___________________ Date of Birth (Day/Month/Year) _______/ _______/________

Address ____ Unit # _________ City ___________________ Province ___________ Postal Code _______________

Phone: Home __________________ Cell __________________ Email (optional) ____

Emergency Contact: Name ___________________________________ Number ______________________ Relationship ________________________________

Physician Name ____ Phone and/or Address ____

Dental Insurance ❑Yes ❑No If yes, Insurance Company ____ Employer _________________________________

Group Policy Number ___________________________ Certificate/ID Number ___________________________ Division Number ___________________________

Referred by ❑Online ❑Website ❑Friend ❑Other ____

MEDICAL HISTORY QUESTIONNAIRE

The following information will assist us in providing you with the best possible dental care. All information provided below will be kept confidential.

1. Are you being treated for any medical condition(s) within the past year?........ ❑Yes ❑No ❑Not Sure/Maybe
2. Have there been any changes in your general health in the past year?........ ❑Yes ❑No ❑Not Sure/Maybe
3. Have you ever been hospitalized?........ ❑Yes ❑No ❑Not Sure/Maybe
   Specify: ____
4. Do you have any heart or circulatory problems of any kind?........ ❑Yes ❑No ❑Not Sure/Maybe
5. Have you ever had rheumatic fever?........ ❑Yes ❑No ❑Not Sure/Maybe
6. Do you have any allergies?........ ❑Yes ❑No ❑Not Sure/Maybe
   Specify: ____
7. Are you presently taking any medications?........ ❑Yes ❑No ❑Not Sure/Maybe
   Specify: Medication _____________________________________ Reason _________________________________
   Medication _____________________________________ Reason _________________________________
   Medication _____________________________________ Reason _________________________________
8. Do you bleed or bruise easily?........ ❑Yes ❑No ❑Not Sure/Maybe
9. Are you pregnant?........ ❑Yes ❑No ❑Not Sure/Maybe
10. Do you presently or have ever had: (Please check)
    ❑Anaemia ❑Arthritis ❑Asthma ❑Blood disorder ❑Cancer ❑Diabetes
    ❑Epilepsy ❑Heart Attack ❑Haemorrhage ❑High/Low BP ❑HIV/AIDS ❑Kidney Disease
    ❑Liver Disease ❑Lung Disease ❑Osteoporosis ❑Pacemaker ❑Rheumatic Fever ❑Steroid Therapy
    ❑Stomach Ulcer ❑Stroke ❑Thyroid Problem ❑Tuberculosis
11. Have you ever had a concussion?........ ❑Yes ❑No ❑Not Sure/Maybe
12. Have you ever fainted?........ ❑Yes ❑No ❑Not Sure/Maybe
13. Have you ever had any illnesses not included in the above?........ ❑Yes ❑No ❑Not Sure/Maybe
    Specify: ____

DENTAL HISTORY QUESTIONNAIRE

1. How frequently do you see your dentist? ❑3 Months ❑6 Months ❑Other______________ Last Dental Visit _______________________
2. Have you ever been given oral hygiene instruction in: ❑Brushing ❑Flossing ❑Other ____
3. Have you ever had local anaesthesia?........ ❑Yes ❑No ❑Not Sure/Maybe
   Any complications? ____
4. Do your gums feel swollen or tender?........ ❑Yes ❑No ❑Not Sure/Maybe
5. Do you catch food between your teeth?........ ❑Yes ❑No ❑Not Sure/Maybe
6. Are you aware of any loose teeth?........ ❑Yes ❑No ❑Not Sure/Maybe
7. Have you ever had a full mouth series of xrays?........ ❑Yes ❑No ❑Not Sure/Maybe
8. Does your jaw crack, pop, or grate when you open widely?........ ❑Yes ❑No ❑Not Sure/Maybe
9. Do you grind or clench your teeth?........ ❑Yes ❑No ❑Not Sure/Maybe

PATIENT ACKNOWLEDGEMENT AND CONSENT

To the best of my knowledge, I certify that the above medical and dental information is correct, and I have not omitted any pertinent information. I hereby consent to the performing of all dental and surgical treatments deemed necessary or advisable, including the use of local anaesthetic. I acknowledge that I will assume full responsibility for the payment of all fees associated with these procedures. I acknowledge that my insurance plan may not cover all services provided, but that I will be responsible for the full payment of all fees.

Patient/Parent/Guardian Signature ____ Date ____