

Northern Lights Dental Clinic

1984 Regent Street Unit 27 , Phone : 705-522-1600

New Patient Information & Medical History Form

SECTION 1 – PATIENT INFORMATION

Legal Name: _____

Preferred Name: _____

Date of Birth (DD/MM/YYYY): _____

Age: _____ Male Female Other Prefer not to say

Address:

Street: _____

City: _____ Province: _____ Postal Code: _____

Phone:

Home: _____ Cell: _____ Work: _____

Email: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

SECTION 2 – RESPONSIBLE PARTY (if patient is a minor or dependent)

Name: _____

Relationship to Patient: _____

Phone: _____

Email: _____

SECTION 3 – DENTAL INSURANCE INFORMATION (if applicable)

Insurance Provider: _____

Policy / Group Number: _____

Certificate / Member ID: _____

I understand that I am responsible for any portion not covered by insurance.

MEDICAL HISTORY

Family Physician Name: _____

Name of

Pharmacy: _____

Physician Phone: _____

Pharmacy Phone

: _____

Please provide list of medications and contact of your Pharmacy to request list of current medication

Do You Have any of Listed medical conditions (Please check YES or NO for each condition)

Cardiovascular

Condition	YES	NO
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
History of heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat / arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker / defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory

Condition	YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine & Metabolic

Condition	YES	NO
Diabetes (Type I or II)	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Adrenal disorder	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

Neurological

Condition	YES	NO
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures / epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal

Condition	YES	NO
Acid reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>

Ulcerative colitis
Liver disease

Musculoskeletal

Condition	YES	NO
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement (hip/knee/etc.)	<input type="checkbox"/>	<input type="checkbox"/>
TMJ disorder	<input type="checkbox"/>	<input type="checkbox"/>

Hematologic / Immune

Condition	YES	NO
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Immune disorder	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>

Infectious Diseases

Condition	YES	NO
Hepatitis (A, B, C)	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
MRSA	<input type="checkbox"/>	<input type="checkbox"/>

Mental Health

Condition	YES	NO
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Panic disorder	<input type="checkbox"/>	<input type="checkbox"/>
PTSD	<input type="checkbox"/>	<input type="checkbox"/>

Cancer & Other Conditions

Condition	YES	NO
Cancer (past or present)	<input type="checkbox"/>	<input type="checkbox"/>
Radiation or chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Additional Medical Conditions applicable (not listed above):

Allergies

- None
- Medications: _____
- Latex
- Foods
- Other: _____

Describe reaction:

Women's Health

Are you pregnant or breastfeeding? Yes No N/A

SECTION 5 – DENTAL HISTORY & ORAL HYGIENE

Reason for today's visit / chief concern: _____

Dental Symptoms

- Tooth pain
- Sensitivity (hot/cold/sweet)
- Bleeding gums
- Swollen gums
- Loose teeth
- Jaw pain / clicking
- Grinding or clenching
- Bad breath

Oral Hygiene Habits

How many times per day do you brush?

- Once Twice Three or more

How many times per day do you floss or clean between teeth?

- Never Less than once daily Once daily More than once daily

Habits

Do you smoke or vape? Yes No , If Yes Please specify frequency and type : _____

Alcohol consumption: None Occasional Regular

SECTION 5A – DENTAL ANXIETY ASSESSMENT

Do you experience dental anxiety or fear?

- No
 Yes

If YES, please indicate the level that best describes you:

- Mild anxiety
 Moderate anxiety
 Severe anxiety / Dental phobia

SECTION 5B – DENTAL TREATMENT HISTORY

Have you received dental treatment in the past?

- Yes No

Previous Dental Office / Dentist Name (if known): _____

Approximate date of last dental treatment: _____

Please check all dental treatments you have had in the past

- Dental examinations / check-ups
- Dental cleanings (scaling / polishing)
- X-rays / radiographs
- Fillings (white or silver)
- Crowns / caps
- Bridges
- Root canal treatment
- Extractions (tooth removal)
- Wisdom teeth removal
- Dentures (full or partial)
- Dental implants
- Periodontal (gum) treatment / deep cleaning
- Orthodontic treatment (braces / Invisalign)
- Oral surgery
- Night guard / mouth guard
- Veneers / cosmetic dentistry
- Teeth whitening

Past Dental Complications

Have you ever experienced problems during or after dental treatment?

- No
- Yes (please check all that apply):

- Difficulty getting numb
- Prolonged bleeding
- Severe pain after treatment
- Infection
- Allergic reaction
- Nausea / fainting
- Jaw pain or locking
- Other: _____

Please explain if YES:

Anesthetic & Sedation History

Have you had local anesthetic (freezing) before? Yes No

If yes, was it effective? Yes No Sometimes

Have you ever had sedation for dental treatment?

- No
- Yes – Nitrous oxide Oral sedation IV sedation

Any adverse reactions to anesthetic or sedation?

No Yes (please explain):

Authorization

I hereby certify that i have read and understand the previous information and that is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and / or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs , study models , scans , photographs or other diagnostic aids deemed appropriate

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependant(s) to a third party insurance carrier, payors, and / or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account

I understand that i am financially responsible for any outstanding balance for services provided that are not fully covered by insurance , and i may be billed for this remaining balance . I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependent's (if any)

Patient Name : _____

Dentist

Name : _____

Patient Signature : _____

Dentist

Signature: _____

Date : _____