ARI DENTAL OFFICE

NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office.

BASIC INFORMATION

Legal First/Given Name(s) _____

Preferred Name _____

Legal Last/Family Name _____

Date of Birth _____

Phone Number _____

Email _____

Preferred Contact Method _____

Mailing Address _____

City _____

Province _____

Postal Code _____

TYPE OF APPOINTMENT

__ New Patient / __ Emergency / __ Consultation / __ Dental Cleaning and Checkup / __ Other

Please Explain:

_____

_____

DENTAL HISTORY

When was your last dental visit? _____

When was your last professional cleaning? _____

Previous dentist (name/clinic and city) _____

When were your last dental x-rays taken? _____

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46 John St.
T: 416 977-1414
E: staff@ari.dental

KING ST WEST
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T: 416 645-3344
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E: info@ari.dental

QUEEN ST WEST
1051 Queen St. W
T: 416 516-5757
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Current Dental Concerns

Chief complaint or reason for initial visit:

Are you currently experiencing any pain or sensitivity? **Y / N / Sometimes**

If yes, where is the pain and/or sensitivity located:

Do your gums bleed when brushing or flossing? **Y / N / Sometimes**

Do you have sensitivity to hot, cold, or sweets? **Y / N / Sometimes**

Do you have jaw pain, clicking, or popping? **Y / N**

Do you experience dry mouth? **Y / N / Sometimes**

Do you experience persisting bad breath? **Y / N / Sometimes**

Past Dental Treatments

Which of the following dental treatments have you had? (Check all that apply):

__ Fillings (amalgam/silver)
__ Fillings (composite/white)
__ Crowns/Caps
__ Bridges
__ Implants
__ Root Canal (endodontic treatment)
__ Tooth Extractions
__ Wisdom Teeth Removal
__ Orthodontics (braces/Invisalign)
__ Periodontal (gum) Treatment
__ Dentures (partial or full)
__ Teeth Whitening
__ Veneers
__ Oral Surgery
__ None of the Above

Have you had any other dental work not listed above? Describe any other dental procedures:

_____

_____

_____

Oral Hygiene Habits

How often do you brush your teeth?

__ Less Than Once a Day / __ Once a Day / __ Twice a Day / __ Three or More Times a Day

How often do you floss? **__ Never / __ Rarely / __ A Few Times a Week / __ Daily**

Do you use mouthwash? **Y / N**

Do you use an electric toothbrush? **Y / N**

Habits and Risk Factors

Do any of the following apply to you? (Check/circle all that apply):

__ Teeth grinding/clenching (bruxism)

__ Nail Biting

__ Chewing ice or hard objects

__ Mouth breathing

__ Tobacco use (cigarettes, chewing tobacco, e-cigarettes/vape pens)

__ Frequent sugary drinks and/or snacks

__ Acid reflux and/or frequent vomiting

__ None of the above

Do you wear a nightguard or mouthguard? **Y / N**

Do you have any oral piercings? **Y / N**

Oral Cancer Screening

Have you ever had an oral cancer screening? **Y / N / Not Sure**

Have you noticed any sores, lumps, or lesions in your mouth that don't heal? **Y / N / Note Sure**

Do you have difficult swallowing? **Y / N**

Do you have persistent hoarseness or voice changes? **Y / N**

Is there a family history of oral or throat cancer? **Y / N / Not Sure**

Additional Notes – is there anything else we should know about your dental history? Please share any other relevant information:

_____

_____

_____

MEDICAL HISTORY

Are you being treated for any medical conditions now or within the past year? **Y / N / Not Sure**

Have there been any changes in your general health in the past year? **Y / N**

When was your last medical checkup? _____

List any prescription or non-prescription drugs you are taking or have recently taken including birth control pills: _____

_____

_____

Do you have any allergies? **Y / N / Not Sure**

_____

Have you ever had a peculiar or adverse reaction to any medicines or injections? **Y / N / Not Sure**

_____

Do you have, or have you ever had, any heart or blood pressure problems (heart or stroke)? **Y / N**

_____

Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve), or have you ever had rheumatic fever? **Y / N**

_____

Do you have any prosthetic or artificial joints (hip, knee, etc.)? **Y / N**

_____

Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? **Y / N**

_____

Have you ever been hospitalized for any illness or operation? **Y / N**

_____

Indicate which of the following you presently have, or ever had: (please check all that apply)

__ Asthma
__ Bronchitis
__ HIV+
__ Diabetes
__ Kidney Disease
__ Nervous Disorder
__ Emphysema
__ Thyroid Disease
__ Hepatitis B or C
__ Glandular Disorders
__ Jaundice
__ Organ Transplant / Medical Transplant
__ Liver Disease
__ Stomach or Intestinal Problems
__ Lung Disease
__ Epilepsy or Seizures
__ Tuberculosis
__ Ulcers

MEDICAL HISTORY

Do you currently have, or ever had in the past, any disease, condition or medical issue not previously listed? **Y / N**

Are there any diseases or medical problems that run in your family? **Y / N**

Are you a smoker? **Y / N**

Are you pregnant or breast feeding? **Y / N / Not Sure**

I certify that I have provided an accurate and complete personal and dental/medical history to the best of my knowledge. All information is confidential and is accessed only via a secure, encrypted interface. Should there be any change in my personal or health status in the future, 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 by or to my medical doctor or another health care provider may be necessary. 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. I understand that 48 hours' notice is required for changing or cancellation of my appointments, otherwise there is $50 charge per hour that may be applied.

Patient, Parent or Guardian's Signature **Date**

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