## CONFIDENTIAL PATIENT QUESTIONNAIRE

Your cooperation in completing both pages of the questionnaire is essential to help us provide you with the highest possible standard of dental care. All information is strictly confidential and will remain with this office.

NAME _____ DATE _____
Last First Initial

DATE OF BIRTH _ _ / _ _ / _ _ _ _ SEX: Male/Female OCCUPATION _____
DD MM YEAR

Do you have any family members attending this clinic? If so, please specify list.

_____

HOW DID YOU HEAR ABOUT YORK DENTAL? _____

ADDRESS _____
Street # and Name Apt # City Prov. Postal Code

HOME PHONE_____ BUSINESS _____ CELL _____

EMAIL _____

DENTAL INSURANCE YES / NO NAME OF INSURANCE COMPANY _____

PERSON RESPONSIBLE FOR ACCOUNT: ☐ SAME AS ABOVE OR _____

_____
Name Address Phone

IN CASE OF EMERGENCY _____
Name Relation phone number

### MEDICAL HISTORY

1. Date of last medical exam with family Doctor_____
2. Are you currently under the care of a physician? ❑ YES ❑ NO
3. Name of Physician _____ Phone _____
4. Are you having dental discomfort at this time? ❑ Yes ❑ No
   Please specify _____
5. Have you been under regular care by a dentist? ❑ Yes ❑ No
6. Previous Dentist? _____ Last visit? _____
7. What was done at that time? _____
8. Have you ever had a problem with local or general anesthetic? ❑ Yes ❑ No
9. Are you tense during dental visits? ❑ Yes ❑ No
10. Have you had any major surgeries in the last 12 months? ❑ Yes ❑ No
11. List of current medication(s) _____
    _____

**Please complete next page**

12. Do you have any allergies? ie: Penicillin. ❑ YES ❑ NO
    If yes, please specify _____
13. Do you use tobacco products? ❑ YES ❑ NO Frequency per day? _____
14. Do you use a vaping device? ❑ YES ❑ NO Frequency per day? _____
15. Do you use cannabis products? ❑ YES ❑ NO Frequency per day? _____

16. Have you ever suffered from or been treated for? (Please circle)

| | | | |
|---|---|---|---|
| *Anemia* | *Dizzy Spells / Fainting* | *Hepatitis A B C* | *Pacemaker* |
| *Arthritis* | *Drug Dependence* | *Herpes* | *Psychiatric Problems* |
| *Artificial Joints/Prosthesis* | *Earaches* | *High Blood Pressure* | *Respiratory Problems* |
| *Artificial Valve* | *Eating Disorder* | *HIV / AIDS* | *Scarlet Fever* |
| *Asthma* | *Endocarditis* | *Hives* | *Sinus Problems* |
| *Blood Disorder* | *Emphysema* | *Jaundice* | *Stroke* |
| *Cancer* | *Epilepsy* | *Latex Allergy* | *Thyroid Problems* |
| *Chemo Therapy/Radiation* | *Excessive Bleeding* | *Liver Problems* | *Tuberculosis* |
| *Chest Pain* | *Headaches* | *Low Blood Pressure* | *TMD (Jaw pain)* |
| *Cholesterol* | *Hearing Problems* | *Mobility (ie: wheelchair)* | *Tumors* |
| *Cold Sores / Herpes* | *Heart Attack and/or Heart Disease* | *Multiple Sclerosis* | *Ulcer* |
| *Diabetes* | *Heart Murmur* | *Osteoporosis* | |

17. I agree that York Dental will not be held responsible for understanding the details of my insurance coverage. I am responsible for all fees associated with my treatment not covered by my insurance.
18. Are there other medical concerns or conditions not listed above? ❑ Yes ❑ NO
    If yes, Please specify _____ _____
19. Women: Are you pregnant? ❑ YES ❑ NO If yes how many weeks?_____ _____

20. Do your gums feel tender or swollen? ❑ Yes ❑ No
21. Are you aware of any lumps or swelling in your mouth? ❑ Yes ❑ No
22. Do you wish to keep your natural teeth? ❑ Yes ❑ No
23. Would you be interested in improving the appearance of your teeth? ❑ Yes ❑ No
24. Describe in your own words what you would like done with your teeth?
    _____
    _____
25. Do you currently experience? (Please Circle)

| | | |
|---|---|---|
| Loose Teeth | Bleeding Gums | Popping / Clicking in the jaw joints |
| Sensitive Teeth | Bad Breath | Unsatisfactory Dentures |
| Neck Pain | Missing Teeth | Spaced or Crooked teeth |
| Nosebleeds | Gagging | Sore Gums |
| TMD (Jaw pain) | | |

**INFORMED CONSENT**

I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, and I will assume responsibility for fees associated with those procedures.

_____ _____
Patient (Parent/Guardian) Signature Date