Clover Hills Dental
Family & Cosmetic Dentistry

Thank you for choosing Clover Hills Dental, we are excited you are here!

At Clover Hills Dental we are committed to providing you excellence in dental health and complete wellness. Please fill out this confidential patient form to help us best care for you. If you have any questions or need assistance, please ask us – we are always happy to help!

GENERAL INFORMATION

☐Mr. ☐Mrs. ☐Ms. ☐Miss First name: _____ Last name: _____

Preferred name: _____ Birth date (mm/dd/year): _____ Sex: ☐M ☐F

Mailing address: _____ City: _____ Province: _____ Postal code: _____

Email address: _____ Home phone: _____ Cell phone: _____

Preferred method of contact: _____ Best time to contact: _____ Occupation: _____

If the above patient is a minor, has a guardian or caregiver, please name the person legally responsible: _____

Relationship to patient: _____ Home phone: _____ Cell phone: _____

How did you hear about our office: _____ Name other family members seen here: _____

Would you like to receive email and text communications, which include appointment confirmations? ☐Yes ☐No

MEDICAL HISTORY

Your mouth is connected to the health of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Your answers will only be used by Clover Hills Dental. Thank you.

Are you currently under the care of a physician? ☐Yes ☐No Purpose: _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

In case of emergency, notify: _____ Phone: _____ Other phone: _____

DO YOU HAVE or HAVE YOU EVER HAD:

1. An allergic reaction to:

☐Aspirin ☐Acetaminophen ☐Penicillin ☐Tetracycline ☐Local anesthetic
☐Ibuprofen ☐Codeine ☐Erythromycin ☐Sulpha ☐Latex
☐Metals (nickel, gold, silver, _____) ☐Other: _____ ☐None of the above

	YES	NO
2. Hospitalization for illness _____	☐	☐
3. Heart problems, or cardiac stent in the last six months ___	☐	☐
4. History of infective endocarditis _____	☐	☐
5. Artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. Pacemaker or implantable defibrillator_____	☐	☐
7. Artificial prosthesis (heart valve or joints)_____	☐	☐
8. Rheumatic or scarlet fever_____	☐	☐
9. High or low blood pressure_____	☐	☐
10. A stroke (taking blood thinners) _____	☐	☐
11. Anemia or other blood disorder _____	☐	☐
12. Prolonged bleeding due to a slight cut (INR>3.5) _____	☐	☐
13. Emphysema, sarcoidosis _____	☐	☐
14. Tuberculosis _____	☐	☐
15. Asthma_____	☐	☐
16. Breathing or sleep problems (i.e. snoring, sinus)_____	☐	☐
17. Kidney disease_____	☐	☐
18. Liver disease _____	☐	☐

	YES	NO
19. Jaundice _____	☐	☐
20. Thyroid, parathyroid disease, or calcium deficiency ___	☐	☐
21. Hormone deficiency_____	☐	☐
22. High cholesterol or taking statin drugs _____	☐	☐
23. Diabetes (HbA1c=_____) _____	☐	☐
24. Stomach or duodenal ulcer_____	☐	☐
25. Digestive disorders (i.e. gastric reflux) _____	☐	☐
26. Osteoporosis / osteopenia _____	☐	☐
27. Arthritis _____	☐	☐
28. Autoimmune disease _____	☐	☐
29. Glaucoma_____	☐	☐
30. Contact lenses _____	☐	☐
31. Head or neck injuries _____	☐	☐
32. Epilepsy, convulsions (seizures) _____	☐	☐
33. Neurologic problems (attention deficit disorder)_____	☐	☐
34. Viral infections and cold sores _____	☐	☐
35. Any lumps or swelling in the mouth _____	☐	☐

	YES	NO
36. Venereal disease	☐	☐
37. Hepatitis (type _____)	☐	☐
38. HIV/AIDS	☐	☐
39. Tumor, abnormal growth	☐	☐
40. Radiation therapy	☐	☐
41. Chemotherapy	☐	☐
42. Anxiety	☐	☐
43. Psychiatric treatment	☐	☐

ARE YOU:	YES	NO
44. Alcohol / drug dependency	☐	☐
45. Presently being treated for any other illness	☐	☐
46. Aware of a change in your general health	☐	☐
47. Subject to frequent headaches	☐	☐
48. A smoker or smoked previously	☐	☐
49. FEMALE - taking birth control pills	☐	☐
50. FEMALE – pregnant	☐	☐
51. MALE - prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic / development delay, or other treatment that may possibly affect your dental treatment (i.e. botox, collagen injections):

_____

List all medications, supplements, and or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your previous dentist: _____ How long were you a patient: _____

Date of most recent dental exam (mm/dd/year): _____ Date of most recent x-rays (mm/dd/year): _____

Date of most recent treatment other than a cleaning (mm/dd/year): _____

I routinely see a dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What are your dental goals? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
1. Have you ever had an unfavorable dental experience?	☐	☐

If so, please explain: _____

GUM AND BONE

	YES	NO
2. Do your gums bleed when brushing or flossing?	☐	☐
3. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
4. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
5. Is there anyone with a history of periodontal disease in your family?	☐	☐
6. Have you ever experienced gum recession?	☐	☐
7. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
8. Have you experienced a burning sensation in your mouth?	☐	☐

TOOTH STRUCTURE

	YES	NO
9. Have you had any cavities within the past 3 years?	☐	☐
10. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
11. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
12. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
13. Do you have grooves or notches on your teeth near the gum line?	☐	☐
14. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
15. Do you get food caught between any teeth?	☐	☐

BITE HEALTH	YES	NO
16. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
17. Do you have any problems chewing gum?	☐	☐
18. Do you have any problems chewing bagels, baguettes, protein bars, or other hard foods?	☐	☐
19. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
20. Are your teeth crowding or developing spaces?	☐	☐
21. Do you have trouble finding your bite or need to squeeze, or shift your jaw to make your teeth fit together?	☐	☐
22. Do you place your tongue between you teeth or close your teeth against your tongue?	☐	☐
23. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
24. Do you clench or grind your teeth in the daytime or make them sore?	☐	☐
25. Do you have any problems with sleep or wake up with a headache or an awareness of your teeth?	☐	☐
26. Do you wear or have you ever worn a bite appliance?	☐	☐

ORTHODONTIC HISTORY	YES	NO
27. Have you ever had orthodontic treatment?	☐	☐
If yes, do you have any crowding or relapse?	☐	☐
28. Do you wear a retainer or night guard?	☐	☐

SMILE CHARACTERISTICS	YES	NO
29. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
30. Have you ever whitened your teeth?	☐	☐
31. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
32. Have you been disappointed with the appearance of previous dental work?	☐	☐

OUR PRACTICE POLICIES

CANCELLATION AND SHORT NOTICE:

We kindly request two business days notice to cancel or reschedule an appointment with our office. Short notice and no show appointments will require a fee of $50.00. We will be happy to assist you in rescheduling this appointment with our first available opportunity or a more suitable time to your calendar.

We appreciate the value of your time and we take pride in being prompt and doing our very best to be on time for you. If you know you are going to be late, please call our office to let us know and we will do our best to continue to see you. With a late arrival of more than 15 minutes, your appointment may be required to be rescheduled.

FINANCIAL:

For your convenience, we accept Visa, MasterCard and debit card. We do not accept personal cheques. Payment for treatment is due at the time of service rendered. If you have questions regarding your account, please contact us and we will be happy to assist you.

DENTAL BENEFITS:

If you have dental benefit coverage, it should be considered as a means of assisting you with the cost of maintaining your oral health, which is connected to your overall health.

Since the Privacy Act was introduced in 2004, insurance companies often will not share the details of your plan with us. It is your responsibility to know what your coverage is.

Our office direct bills over 100 different insurance companies and policies, each having their own rules and regulations. For plans that accept electronic claim filing, we offer the service option of directly billing your insurance company for your appointments. Please be aware that your insurance coverage is a contract between the policy holder, the insurance company and the employer, not the dentist. If you have any questions or changes to your dental benefits, our Administrative Team will be happy to assist you.

I have dental benefits I wish to use: Yes ☐ No ☐

Patient's / Guardian / Caregiver Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____