HAREWOOD DENTAL

Dr. Katharine Gillanders and Associates

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Legal Name: ____

Pref Name: __________________ **Gender:** M F O **Birth Date:** (MM/DD/YY)______________

Parent(s) / Guardian Name(s) (if minor): ____

Mailing Address: ____

City & Province: ______________________________________ **Postal Code:** _____________________

Home Phone: ____________________________ **Work Phone:** _________________________________

Cell Phone: _____________________________ **Best Number for Contact:** Home Work Cell

Email Address (for appointment reminders):____

Physician (Name & Phone #):____

Previous Dentist (Name & Phone #):____

Emergency Contact (Name & Phone #):____

Who can we thank for referring you? ____

DENTAL HEALTH HISTORY

(Please check all that apply, leave any that do not apply blank)

- Apprehensive about dental treatment
- Had problems with previous treatments
- Gag easily
- Wear Dentures
- Food catches easily between teeth
- Avoid brushing any part of your mouth

Do your gums:

- Bleed when flossing
- Bleed when brushing
- Feel swollen or tender

- Dry mouth
- Burning tongue
- Slow healing sores in/near mouth
- Dissatisfied with appearance of teeth
- Sensitive teeth

Twinges when teeth come in contact with:

- Hot foods or liquids
- Cold foods or liquids
- Sweets

How often do you brush?______floss?_______a day

How often do you use mouth rinse? _____________

- Fluoride supplements (high F toothpaste/rinse)
- Pain in face, cheeks, jaws, joints, throat, temples
- Uncomfortable bite
- Habitual gum chewer
- Jaw issues (eg. TMD, pain, popping/crackling, etc)
- Sleep apnea

* Is there anything else you would like to discuss?

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MEDICAL HEALTH HISTORY

(Please check all that apply, leave any that do not apply blank)

Do you have, or have you had, any of the following?

Heart Problems

- Chest pain/Shortness of breath
- Heart Attack, date:________________
- Blood pressure problem (high/low)
- Heart murmur
- Rheumatic fever
- Pacemaker
- Artificial heart valve
- Heart arrhythmia
- High cholesterol
- Require pre-med for appointments

Blood Problems

- Easy bruising
- Frequent nosebleeds
- Abnormal bleeding
- Blood disease (anemia)
- Had a blood transfusion

Allergy Problems

- Hay fever
- Skin rashes
- Sinus problems
- Asthma

Intestinal Problems

- Ulcers
- Weight loss or gain
- Special diet
- Kidney or bladder problems
- Acid reflux

Bone or Joint Problems

- Arthritis
- Back or neck pain
- Joint replacement, date: ____________
- Require pre-med for appointments

Women

- Taking contraceptives/hormones
- Pregnant
  - Expected delivery date: __________
- Nursing

Miscellaneous

- Fainting spells, seizures, or epilepsy
- Stroke(s)
- Frequent or severe headaches
- Thyroid problems
- Persistent cough or swollen glands
- Cancer or tumor
- Diabetes (Type I or Type II)
- Memory loss (Alzheimer's, dementia)
- Tuberculosis or other respiratory disease

- Do you smoke cigarettes? How much? ____
- Do you use marijuana? How much? _______
- History of alcohol or drug use
- Hepatitis, jaundice or liver trouble
- Herpes
- HIV positive / AIDS
- Glaucoma
- Do you wear contact lenses?
- History of head injury
- Hearing trouble
- Autoimmune (lupus, MS, etc.)

Do you have any disease, condition, or problem not previously listed that you feel we should know about?

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Are you ALLERGIC or have you reacted to any of the following?

- Local Anesthetic
- Latex
- Penicillin
- Sulfa drugs
- Erythromycin
- Reaction to metals
- Barbiturates, sedatives or sleeping pills
- Aspirin, Acetaminophen, or Ibuprofen
- Codeine, Demerol, or other narcotics
- Other

Please indicate any medications that you are currently taking, or have taken within 12 months:

- Anticoagulants (eg. Coumadin, Warfarin)
- High Blood Pressure medicine
- Sleep aid (eg. Ativan)
- Insulin, Metformin, or similar drug
- Aspirin
- Digoxin or drugs for heart trouble
- Nitroglycerin
- Cortisone (steroids)

Please list all medications* (prescription and natural remedies)__________________________________

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*You may also provide a list from you pharmacy
Name of Pharmacy - __________________________

OFFICE POLICY

We require 48 business hours of notice for appointment changes. There is a $50 charge for missed appointments and short notice cancellations. The patient portion of fees is due at the time of service. We will accept direct assignment from your insurance company but if for any reason they reject the claim or do not pay the full amount, you remain financially responsible for your account balance.

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of dental treatment (hygiene, restorations, etc.) when fully informed and agreed to be necessary or advisable. I fully understand the office policy and will assume responsibility for fees associated with those procedures performed. I have answered all of the questions above to my best knowledge, recognizing that this is confidential information shared only between myself and the dental professionals at Harewood Dental.

Date: ______________________ **Patient** (or Guardian) **Signature:** ___________________________________