New Patient Questionnaire

Personal Information

Full Name _____ Preferred Name _____

Date of Birth d____ m____ y____ Email _____

Phone 1 _____ Phone 2 _____

Address _____

Employer & Occupation _____

Emergency Contact Information

Name _____ Relation _____

Phone 1 _____ Phone 2 _____

Insurance Information

If you have dental coverage, please fill out the information below. Leave blank if you have no insurance.

Insurance Provider _____ Plan Number _____

ID / Contract Number _____

Name of any other patient (ie. Family Member) covered under this insurance plan:

_____

Dental Information

How many months / years has it been since you've last visited a dentist? _____

Please provide the following information about your previous dentist.

Dentist Name _____ Practice Name _____

City (if not Winnipeg) _____

How did you hear about our clinic? _____

Are you happy with you smile? What are your concerns? What would you change?

_____

_____

_____

ALL SEASONS
DENTAL CLINIC

Check any of the following that apply to you / you are concerned about:

☐ I don't like the colour of my teeth	☐ I'm interested in whitening my teeth
☐ I don't like the alignment of my teeth	☐ I'm interested in Invisalign / Braces
☐ I have difficulty chewing food	☐ I want to replace missing teeth

Are you experiencing any problems with your mouth / teeth?

_____

_____

_____

Check any of the following that you apply to you / you are concerned about:

☐ Sensitive teeth	☐ Pain caused by cold drinks	☐ Pain caused by warm food
☐ Pain when biting down	☐ Pain overnight	☐ Cavities
☐ Bad Breath	☐ Gum Recession	☐ Loose Teeth
☐ Denture is loose	☐ Denture causing pain	☐ I want a new denture

How often do you brush your teeth? ☐ Occasionally ☐ 1x per day ☐ 2x per day ☐ >2 per day

How often do you floss? ☐ Never ☐ Occasionally ☐ 1-2x per week ☐ Every day

Does visiting the dentist make you anxious? ☐ Yes ☐ No

Have you had any issues with a previous dentist or dental visit? What happened?

_____

_____

ALL SEASONS
—DENTAL CLINIC—

Medical Information

Several medical conditions and medications have implications on your oral health and management during dental procedures (ie. Minor surgeries). It is critical to provide us with your complete and accurate medical details so our team can diagnose and manage you individually as safe as possible. All information is strictly confidential.

Physician's Name _____ Clinic Name _____

City (if not Winnipeg) _____

Please list any medications you take regularly – include generic drug name, not brand name if possible.

_____

_____

_____

Please list any medical conditions you've been diagnosed with. _____

_____

_____

Check any that apply to you, if not listed above:

☐ Bleeding Disorder (VWD, Haemophilia)	☐ Osteoporosis
☐ Diabetes	☐ Epilepsy
☐ Asthma, COPD, Breathing Trouble	☐ Liver or Kidney Disease
☐ Crohn's, Coeliac, IBD, Ulcerative Colitis	☐ Peptic Ulcers
☐ Immunodeficiency	☐ Angina / Chest Pain / Previous Heart Attack
☐ Tuberculosis	☐ Transmissible Viral Infection (Ex. Hepatitis)

Have you ever received radiotherapy (cancer treatment) to the head or neck? ☐ Yes ☐ No

Have you ever taken medications for osteoporosis? (Bisphosphonates, Prolia) ☐ Yes ☐ No

Have you had a recent heart attack, stroke, or experienced chest pain? ☐ Yes ☐ No

Do you have any food or medication allergies? (Ex. Penicillin)

Yes _____

No ☐

ALL SEASONS
—DENTAL CLINIC—

Check any of the following that apply, or previously applied to you:

☐ Pacemaker	☐ Prosthetic Heart Valves / Valve Repair
☐ Cyanotic Heart Disease (“Hole in Heart”)	☐ Heart Transplant
☐ Major Joint Replacement (ex. Hip, Shoulder)	

If you answered yes to any of the above, how recent did you have the surgery? _____

Are you, or do you think you could be pregnant? ☐ Yes ☐ No ☐ Not Applicable

Do you have, or are you in a high-risk group of acquiring any transmissible blood borne viruses? (ex. Hepatitis B, HIV) ☐ Yes ☐ No

How many alcoholic drinks do you have a week? _____

Do you smoke or vape? ☐ Yes ☐ No Cigarettes per day: _____

Other than nicotine, have you experienced addiction to any substance?

☐ Yes ☐ No Substance: _____

Consent

Check all which apply, sign at the end.

☐ **General Consent: (Must check to be accepted)**

I consent to dental procedures (fillings, crowns, bridges, root canals, pulpal treatments, extraction, cleanings) that are agreed to be necessary or advisable, including the use of local anaesthetic and radiographs as indicated. The benefits, risks, and alternative choices will be explained verbally prior to any treatment. I agree to pay all related fees for services provided for myself and/or any person whom I am legal guardian of. I agree and understand that a 2% per month service charge of interest will be my responsibility for any outstanding payments past 60 days.

☐ **Office Policies: (Must check to be accepted)**

I understand that ASDC requires 2 business days of notice for a cancellation, otherwise there will be a charge for a missed appointment.

☐ **Consent for Photography: (Optional)**

I agree to allow ASDC to anonymously use photographs taken for patient education and marketing (ex. Before and after smile pictures of your teeth, not full face portraits).

Patient (Guardian) Signature _____ Date _____