Dr. Valeria Pini 2000 Garth Street Unit 102, Hamilton, ON L9B 0C1
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WELCOME TO OUR OFFICE

Date: ____ / ____ / _____
dd mm year

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.:_____
last first middle

Marital Status: _____ Date of Birth: ____ / ____ / _____
dd mm year

Address: _____
Number Street Apt. unit

_____
City Postal Code

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Referred to our office by: _____

Person responsible for account: _____

Are you a member of a prepaid dental plan? ❑ Yes ❑ No

Do you have co-insurance? ❑ Yes ❑ No

Note: Please bring all dental insurance information to first appointment.

OFFICE USE ONLY

Insurance Company: _____ Subscriber's Names: _____

Plan Number or Name: _____ Group Number: _____

Employee Number: _____ Certificate of Subscriber: _____

Union Local Number: _____

Plan Coverage: _____

MEDICAL QUESTIONNAIRE

Your answers to the following questions are necessary and important for safe and proper treatment of your dental condition by Dr. Pini. **ALL INFORMATION IS STRICTLY CONFIDENTIAL.**

Have you been hospitalized anytime during the past 2 years? ❑ Yes ❑ No

If yes, please give reason. _____

Physician's Name: _____

When was your last medical checkup or visit to your physician? _____

Please give reason. _____

Are you taking any form of prescription or non-prescription medication (pills)? ❑ Yes ❑ No

If yes, list them. _____

_____

Are you allergic to: ❑ Penicillin ❑ Aspirin ❑ Anaesthetic ❑ Codeine ❑ Latex ❑ Other: _____

Do you smoke or chew tobacco? ❑ Yes ❑ No

Do you have or have you ever had any of the following? Check yes or no.

Yes	No		Yes	No		Yes	No	
❑	❑	Alcohol/Drug Abuse	❑	❑	Diabetes	❑	❑	Pacemaker
❑	❑	AIDS/HIV positive	❑	❑	Eating Disorders	❑	❑	Psychiatric Care
❑	❑	Anaemia	❑	❑	Epilepsy	❑	❑	Rheumatic Fever
❑	❑	Arthritis	❑	❑	Eye Surgery	❑	❑	Sinus Problems
❑	❑	Asthma/Bronchitis	❑	❑	Head/Neck Injuries	❑	❑	Thyroid Problems
❑	❑	Bleeding Problems	❑	❑	Heart Attack	❑	❑	Ulcers
❑	❑	Blood Disorder (Leukemia)	❑	❑	Heart Murmur/MVP	❑	❑	Venereal Disease
❑	❑	Blood Pressure Problems	❑	❑	Heart Valve Problems	❑	❑	Prosthetic Joint
❑	❑	By Pass Surgery	❑	❑	Hepatitis	❑	❑	Radiation Treatment
❑	❑	Cancer	❑	❑	Kidney Problems	❑	❑	Stroke
❑	❑	Chest Pains	❑	❑	Liver Problems			
❑	❑	Circulation Problems	❑	❑	Lung Disease/TB			

For women only, are you pregnant? ❑ Yes ❑ No If yes, deliver date: _____

Is there anything else we should know? _____

_____

All Patients: A consultation with your medical doctor may be necessary to ensure safe dental treatment for you.
To the best of my knowledge the above information is presently correct. Should there be any changes in my health status in the future it is my responsibility to advise this dental office prior to any dental treatment.

Signature: _____ Date: _____

Reviewed by Treating Dentist: _____

DENTAL HISTORY QUESTIONS

When was your last dental visit? _____

When did you last have dental x-rays? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have you been seeing a dentist regularly? ..... ❑ Yes ❑ No
Do any of your teeth ache? ..... ❑ Yes ❑ No
Have you ever been advised to take antibiotics before dental appointments? ..... ❑ Yes ❑ No
Do your gums bleed when you brush? ..... ❑ Yes ❑ No
Do you have pain when you chew? ..... ❑ Yes ❑ No
Do you have pain or soreness around your ears or jaw muscles? ..... ❑ Yes ❑ No
Are you aware of your jaw joints popping or clicking? ..... ❑ Yes ❑ No
Have you ever been in a vehicle accident or had blows to your jaw? ..... ❑ Yes ❑ No
Have you ever had any implant surgery by a dental specialist? ..... ❑ Yes ❑ No
Are you satisfied with your teeth and their appearance? ..... ❑ Yes ❑ No
Is there anything else we should know regarding your past dental history? ..... ❑ Yes ❑ No

Comments: _____

_____

All Patients: Some dental insurance companies request information such as X-rays, to determine coverage. A nominal cost is assessed for those patients whose plans request this information, for cover of postage etc. The patient is responsible for all costs any may be reimbursed by their insurance companies according to the type of coverage.

I hereby allow Dr. Pini to obtain/release information, as noted above, as required.

Signature: _____ Date: _____

OFFICE USE ONLY: **COMPREHENSIVE DENTAL EXAMINATION**

EXTRA-ORAL EXAM	**INTRA-ORAL EXAM**
TMJ Dysfunctional	Tongue
Cervical Lymphadenopathy	Soft and Hard Palate
Facial Asymmetry	Floor or mouth
Vital Signs	Cheek/Lips
Arch and Incisor Relationship	Cancer check