Medical Alert (Office Use Only)	Condition	Premedication	Allergies	Anaest.

DENTAL HISTORY

Date of your last dental visit: _____ Date of your last dental cleaning: _____

Date of your last complete set of x-rays: _____

		NO	YES
1.	Do you visit the dentist regularly? How often? _____	☐	☐
2.	Are you having any pain or are you aware of any dental problems?	☐	☐
	_____		
3.	Do you have any questions or concerns about your teeth? _____	☐	☐
	_____		
	_____		
4.	Have you ever had any of the following?		
	Periodontal treatment? (treatment of the gums)	☐	☐
	Orthodontic Treatment? (to straighten or realign teeth)	☐	☐
	Oral Surgery? (Surgery in or about the mouth)	☐	☐
	Teeth Extracted? Reason _____	☐	☐
	Have you had your wisdom teeth extracted?	☐	☐
	Your bite adjusted or teeth ground?	☐	☐
	Dental Implants?	☐	☐
5.	Are there any growths or sore spots in your mouth?	☐	☐
6.	Do you suffer from pain or swelling of your gums?	☐	☐
7.	Have you noticed any loose teeth?	☐	☐
	or, have any of your teeth shifted?	☐	☐
8.	Does food catch between your teeth?	☐	☐
9.	Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐	☐
	_____		
10.	How often do you brush your teeth? _____		
11.	Do your gums bleed when brushing or eating? Where? _____	☐	☐
12.	Do you use dental floss? How often? _____	☐	☐
	Do your gums bleed when you floss? Where? _____	☐	☐
13.	Have you ever experienced any of the following jaw problems?		
	Popping/clicking in your jaw joints?	☐	☐
	Pain in your jaw joints, around your ears, or side of your face?	☐	☐
	Difficulty in opening or closing?	☐	☐
	Pain when teeth are clenched?	☐	☐
	Pain or difficulty while chewing?	☐	☐
14.	Do you have any of the following habits?		
	Clenching or grinding your teeth while awake or asleep?	☐	☐
	Biting your cheeks or lips?	☐	☐
	Mouth breathing while awake or asleep?	☐	☐
	Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)?	☐	☐
15.	Are you happy with the appearance of your teeth?	☐	☐
	or, what would you like to see changed? _____		
	_____		
16.	Do you sense that you have bad breath? _____	☐	☐
17.	Have you ever had an upsetting experience in a dental office,		
	or any complications during or following dental treatment? _____	☐	☐
	_____		
	_____		
18.	Do you have any emotional concerns about having dental treatment? _____	☐	☐
	_____		
	_____		
19.	Do you have any specific requests that would make your visit more pleasant?		
	_____		
	_____		
20.	What is most important to you about your teeth? _____		
	_____		
	_____		
21.	What is most important to you about a dental office? _____		
	_____		
	_____		

Welcome to Dental Care – Dr. C. Binert & Associates

The following information is necessary in order that the dentist may thoroughly diagnose any condition and give you personal attention. Please fill out the form completely. This information is confidential.

PERSONAL INFORMATION

Dr. Mr. Mrs. Miss Ms. Name: _____

Name you would like to be called: _____ Date of Birth: D _____ M _____ Y _____

Home Tel: _____ SIN# (if required by insurance) _____

Cell Tel: _____ Office Tel: _____ Ext: _____

Address: _____ Apt: _____

City: _____ Postal Code: _____

Employer: _____ Occupation: _____

Email Address: _____ Physician: _____

Previous Dentist: _____ Physician's Phone No.: _____

Why have you decided to change dental offices? _____

How did you hear about us? _____

INSURANCE INFORMATION

Name of insured if different from above: _____

Insurance Company: _____ Birth date of insured: D _____ M _____ Y _____

Policy/Group #: _____ Division if applicable: _____

Certificate ID #: _____ Employer: _____

Do you have secondary insurance? _____

IN CASE oF EMERGENCY CONTACT:

Name: _____ Relationship: _____ Tel: _____

MEDICAL HISTORY

The following information is required for medical and legal reasons and is strictly confidential.
All facts are needed for correct diagnosis and safe treatment.

		NO	YES
1.	When did you last see your physician? _____		
	Is your physician treating you now or have you been treated within the past year?	☐	☐
	If yes please list for what _____		
2.	Are you taking any medications, tablets, non-prescription drugs or herbal supplements?	☐	☐
	If yes please list _____		
3.	Have you had an unusual reaction to any drugs or medications or injections?	☐	☐
	If yes, please list _____		
4.	Do you have any allergies? To latex? To medication? Other? _____	☐	☐
5.	Have you taken cortisone or steroids?	☐	☐
6.	Do you have any sinus problems?	☐	☐
7.	Are you a bleeder or do you bruise easily?	☐	☐
8.	Do you have a Pacemaker, (Mitra Valve Prolapse), Congenital Heart Disease, Artificial Heart Valve Heart transplant, Heart disease, Heart murmur or infection of the heart?	☐	☐
9.	Have you ever had jaundice (hepatitis) or liver disease?	☐	☐
10.	For females. Are you pregnant?	☐	☐
	What's your delivery date? _____ or are you breast feeding?	☐	☐
11.	Have you been exposed to the Aids virus?	☐	☐
12.	Do you smoke or chew tobacco? If so, how much?	☐	☐

13. Do you have or have you had any of the following? (circle)

- Chest pain/angina
- Diabetes
- Stroke
- High blood pressure
- Epilepsy
- Cancer
- Leukemia
- Radiation
- Chemotherapy
- Rheumatic Fever
- Thyroid Trouble
- Blood Disorders
- Stomach Ulcers
- Kidney trouble
- Tuberculosis
- Liver Trouble
- Anaemia
- Arthritis
- Asthma
- Heart Attack
- Venereal Disease
- Chronic Lung Disease
- Eating Disorders (i.e. anorexia nervosa, bulimia etc)
- Psychiatric Disorders/treatment
- Drug/Alcohol Drug Dependency
- Shortness of Breath

14.	Did you have any artificial joint replacement surgery?	☐	☐
15.	Please list all hospitalizations and surgeries? _____		
16.	Do you have osteoporosis and are you taking any osteoporosis medications? (Fosamax, Actonel)	☐	☐
17.	Are there any diseases or medical problems that are in your family (e.g. diabetes, cancer or heart disease)	☐	☐
18.	Any other conditions or problems of which the dentist should be aware?	☐	☐

I authorize release, to my insuring company/plan administrator, the information contained in claims and predeterminations submitted. I authorize the use of my study models, photographs and/or x-rays for the purpose of lecturing and publication. I understand that responsibility for payment of the dental service for myself and my dependents is mine, and I assume total and complete responsibility for any and all fees associated with these services.

This is to certify that I, the undersigned, understand that the above information is mandatory for my proper and safe care and that this information is correct and complete to the best of my knowledge. I hereby give permission to collect any third party to verify and expand on information given. Based on any type of consent as explained in this document.

Method of payment: VISA ☐ Mastercard ☐ AMEX ☐ Interac ☐ Cash ☐ Care Credit ☐

Signature of Patient/Parent/Guardian: _____ Date: _____

Reviewed by treating Dentist: _____ Date: _____

CONTINUED ON BACK