hanoverdental

Welcome to our office!

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Name _____

Preferred Name _____ Date of Birth (dd/mmm/yyyy) _____ Gender ☐ Male ☐ Female

Mailing Address _____ City/Province _____ Postal Code _____

Home Phone _____ Cell Phone _____ Email _____

Marital status ☐ Single ☐ Married ☐ Divorced Best contact for courtesy reminders? ☐ Email ☐ Text message ☐ Phone call

Employer _____ Occupation _____ Work Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Other family members under our care _____

How did you hear about our office? ☐ Radio ☐ Online Ad ☐ Newspaper ☐ Google Search ☐ Personal Referral ☐ Other

DENTAL BENEFITS – YOUR INSURANCE COMPANY

Primary Insurance Company Name _____ Group Number _____ ID Number _____

Subscriber Name _____ Subscriber Employer _____

Your Relationship to Subscriber _____ Subscriber Date of Birth (dd/mmm/yyyy) _____

Secondary Insurance Company Name _____ Group Number _____ ID Number _____

Subscriber Name _____ Subscriber Employer _____

Your Relationship to Subscriber _____ Subscriber Date of Birth (dd/mmm/yyyy) _____

DENTAL BENEFITS – YOUR SUMMARY OF COVERAGE

Yearly maximum $_____ Basic %_____ Major %_____ Deductible $_____ Dependent Age Limit _____

1. Does your insurance benefit pay on a calendar year (Jan-Dec)? ☐ Yes ☐ No If no, then what month does it reset? _____

2. Does your insurance benefit pay on the current Dental Fee Guide? ☐ Yes ☐ No, which guide? _____

3. Recall exam frequency? 6 months___ 9 months___ 12 months___

4. Panoramic images frequency? _____

5. Polish or Hygiene cleaning frequency? 6 months___ 9 months___ 12 months___

6. Number of x-rays allowed _____

7. Number of scaling units allowed? _____ Per ☐ Calendar or ☐ Rolling year?

8. Frequency of complete oral exam? _____

9. Number of root planing units allowed? _____ Per ☐ Calendar or ☐ Rolling year?

10. Is fluoride treatment covered? _____

11. Is root canal therapy (endodontics) listed under Basic or Major coverage? _____

12. Are composite (tooth coloured) fillings paid on molars? ☐ Yes ☐ No

13. When was your last dental visit? _____ Was any treatment billed to this insurance policy then? _____

UNIT 33A – 178 PTH 12N, CLEARSPRING CENTRE, STEINBACH, MANITOBA R5G 1T7
Phone: 204.326.6647 Email: smile@hanoverdental.ca
Website: www.hanoverdentalclinic.ca

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DENTAL HISTORY

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

Previous dentist or dental office name _____ How long were you a patient there? _____

Date (month/year) of most recent: Dental Exam ____/____ Dental X-rays ____/____ Dental Treatment ____/____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your primary/immediate dental concern? _____

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	☐	☐
2. Have you ever had complications from past dental treatment? _____	☐	☐

SMILE CHARACTERISTICS	YES	NO
3. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
4. Have you ever whitened/bleached your teeth? _____	☐	☐
5. Are you self-conscious about your teeth? _____	☐	☐
6. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

BITE AND JAW JOINT	YES	NO
7 Do you have any problems chewing foods such as gum, bagels, or hard candy? _____	☐	☐
8. Have your teeth changed in the past 5 years (shorter, thinner, worn, crowding, spaces)? _____	☐	☐
9. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? _____	☐	☐

TOOTH STRUCTURE	YES	NO
10. Have you had any cavities in the past 5 years? _____	☐	☐
11. Do you have a dry mouth? _____	☐	☐
12. Are any teeth sensitive to hot, cold, biting, or sweets? _____	☐	☐
13. Have you ever had a cracked filling, broken, chipped, or cracked adult tooth? _____	☐	☐

GUMS AND JAW BONE	YES	NO
14. Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
15. Have you ever experienced gum recession? _____	☐	☐
16. Do your gums bleed when brushing, flossing, or eating? _____	☐	☐
17. Are your teeth becoming loose over time? _____	☐	☐

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CONFIDENTIAL MEDICAL HISTORY

Although our dental team members primarily treat the area in and around your mouth, your mouth is part 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.

Thank you for reading and answering the following questions so that we can provide you with the best care possible.

Your Name 0 _____ For Office Use Only – patient ID # _____

PHYSICIAN CONTACT INFO & MEDICATION LIST	YES	NO
Name of physician and specialty or your family doctor _____		
Name of clinic or phone number _____ Date of last exam _____		
Are you presently taking any prescriptions, medications, or supplements?_____	☐	☐
Are you presently taking any non-prescription/over-the-counter medications?_____	☐	☐
Please list all prescriptions and medications that you are currenlty taking:_____		
_____		
_____		

If you are taking more than 3 prescriptions and/or medications we can call your pharmacy for a complete list.

Pharmacy Name _____ Permission to contact pharmacy *(please check)* ☐ ☐

If you are unsure of the effect of any medication that you are taking or any medical condition that you have, please discuss it with your dentist or dental hygienist PRIOR to treatment. Our dental team is here to help you!

FOR WOMEN PATIENTS ONLY	YES	NO
Are you pregnant? If yes, how far along are you?_____	☐	☐
Are you nursing?_____	☐	☐

ALL PATIENTS PERSONAL HISTORY	YES	NO
Have you ever had major surgery? What type? _____	☐	☐
Has a medical doctor advised that you need pre-medication prior to dental treatment? _____	☐	☐
Have you ever had a mouth or jaw injury? _____	☐	☐
Have you ever taken medications for Osteoporosis (Fosamax, Zometa, Aredia or any others)?_____	☐	☐
Do you smoke? How often and for number of years?_____	☐	☐
Have you consumed an excessive amount of alcohol or drugs in the last 48 hours? This is confidential. Excessive amounts of alcohol or drugs in your system during dental treatment can seriously affect your heart.	☐	☐
Have you consumed any illegal substances in the last 48 hours? Specifically cocaine? This is confidential. It is unsafe to administer local anesthesia to patients with cocaine in their system as it can seriously affect their heart.	☐	☐

PLEASE TURN OVER PAGE TO COMPLETE QUESTIONS ON THE REVERSE SIDE. THANK YOU.

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ALLERGIES & MEDICAL CONDITIONS	YES	NO

Have you experienced an allergic reaction or are you allergic to any of the following medications?

Penicillin / Amoxicillin _____	☐	☐
Aspirin, Ibuprofen (Advil)_____	☐	☐
Acetaminophen (Tylenol) _____	☐	☐
Codeine, Tylenol #1, #2, #3, #4 _____	☐	☐
Clindamycin _____	☐	☐
Local Anesthetics _____	☐	☐
Latex _____	☐	☐
Metals _____	☐	☐

Please list all other allergies that you have, that are not listed above: _____

_____

<u>Do you HAVE or have you HAD</u> any of the following medical conditions?

CONDITION	YES	NO	CONDITION	YES	NO
Blood Disorders, ie) Anemia _____	☐	☐	Cancer/Tumors _____	☐	☐
Bleeding Disorders _____	☐	☐	Radiation/Chemotherapy_____	☐	☐
Von Willebrand Disease _____	☐	☐	Thyroid/Parathyroid Disease _____	☐	☐
High Blood Pressure _____	☐	☐	Gastric Reflux Disease_____	☐	☐
Low Blood Pressure _____	☐	☐	Asthma_____	☐	☐
Diabetes or Hypoglycemia _____	☐	☐	Lung Disease_____	☐	☐
Heart Attack_____	☐	☐	Osteoporosis_____	☐	☐
Heart Surgery _____	☐	☐	Ulcers _____	☐	☐
Artificial Heart Valve _____	☐	☐	Liver Disease _____	☐	☐
Heart Pacemaker _____	☐	☐	Kidney Disease_____	☐	☐
Heart Murmur _____	☐	☐	Artificial Joints_____	☐	☐
Angina/Chest Pains _____	☐	☐	HIV Exposure_____	☐	☐
Stroke _____	☐	☐	Hepatitis Exposure_____	☐	☐
Seizure Disorder _____	☐	☐	Rheumatic or Scarlet Fever _____	☐	☐

I certify that have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge. As may be required, I consent to my physician being contacted regarding any specific medical questions. I authorize Dr. Luke Singh and Associates to perform necessary diagnostic procedures and treatment. I understand that I am financially responsible for the dental services provided even if my insurance coverage may or may not be all inclusive.

Patient/Guardian Signature _____ Date _____

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