NAME (please print): _____ DATE:_____

Sackville Dental Centre – Medical/Dental Questionnaire

PART 1 – Dental History

- Are you having any dental problems at this time? Y N
- When was your last dental visit? _____ Last Dental X-rays? _____
- How do you feel about the appearance of your teeth?_____
- Do your gums bleed when you brush them? Y N
- Have you ever been given Oral Hygiene instructions? Y N
- Are you nervous about having dental treatment? Y N

PART 2 – Medical History Health Card # _____

- Has there been any change in your general health in the last 2 years? Y N
  If yes, what change? _____
- Are you now under the care of a physician? Y N
  If yes, please explain: _____
- Please list any medications you are taking at this time (prescriptions or otherwise):
  _____
  _____
- Do you have any allergies? Y N
- PENICILLIN, CODEINE, ASPIRIN, LATEX, FOOD (please circle all that apply)
- List any other allergies: _____
- Have you ever had excess bleeding that required special treatment? Y N
- Has there been a change in your weight or appetite lately? Y N
- Have you ever fainted? Y N
- Please circle any of the following, which you HAD, or HAVE at present:

AIDS/HIV	Asthma	Artificial Joint	Arthritis
Blood Transfusion	Cancer	Chemotherapy	Drug Addiction
Diabetes	Epilepsy/Seizures	Fainting	Glaucoma
High Blood Pressure	Hepatitis A,B,C	Kidney Problems	Liver Disease
Lupus	Pain in Jaws/Joint	Psychiatric Treatment	Rheumatic Fever
Rhuematism	Shortness of Breath	Scarlet Fever	Sinus Trouble
Skin Disorder	Stroke	Thyroid Disease	Tuberculosis
Ulcers	STI (Syphilis/Gonorrhea/Herpes)		

- Do you have any have any HEART problems? (please circle all that apply) HEART DISEASE, ATTACK, FAILURE, DEFECT/MURMUR, SURGERY, ANGINA, ARTIFICIAL HEART VALVE, CHEST PAIN, PACEMAKER. Please list any other: _____
- Do you have LUNG problems? LUNG DISEASE, EMPHYSEMA, PERSISTENT COUGH. Please list any other:_____
- Do you have any BLOOD problems? BLOOD DISORDER, HEMOPHILIA, JAUNDICE, SICKLE CELL DISEASE, ANEMIA. Please list any other: _____
- Do you have any disease, condition or problem not mentioned previously? _____
- Do you use tobacco products? Y N If so, what type? _____
- Do you consume alcohol? Y N How often and in what quantity?_____
- WOMEN ONLY: Are you pregnant? Y N

PART 3

- Why did you select our office?_____
- Whom may we thank for referring you? _____
- Emergency Contact: _____ Phone#_____
- Name of Spouse & Children (if applicable):_____
- Medical Doctor's Name:_____ Phone#: _____

Sackville Dental has a 48 hour cancellation policy. Those appointments resulting in short notice cancellations or failed appointments will be subject to an $80 surcharge.

SIGNATURE: _____

NAME (please print): _____ DATE:_____

****Sackville Dental is now offering the convenience of Text and E-mail confirmation.**
E-Mail: _____
Cell: _____

SIGNATURE: _____