MOUNT PLEASANT DENTAL GROUP

MPDG
New Patient Form

WELCOME TO OUR OFFICE

			Account Number
LAST NAME	FIRST NAME	INITIALS	DATE OF BIRTH Y /M /D
ADDRESS			
CITY/PROVINCE			POSTAL CODE
TELEPHONE RESIDENCE	BUSINESS	MESSAGE	
OCCUPATION	EMPLOYER		
WHO MAY WE THANK FOR REFERRING YOU?	CARE CARD NUMBER		
PERSON RESPONSIBLE FOR ACCOUNT	SOCIAL INSURANCE NO.	DO YOU HAVE DENTAL INSURANCE?	

PRIMARY DENTAL INSURANCE

NAME OF INSURER	DATE OF BIRTH Y /M /D		
EMPLOYER			
INSURANCE CARRIER			
GROUP/POLICY NUMBER	DIVISION		
I.D. NUMBER OR S.I.N.			
CERTIFICATE NUMBER A ☐ B ☐ C ☐ D ☐			
LIMITS BASIC ☐ MAJOR ☐ ORTHO ☐			
DEDUCTIBLE BASIC ☐ MAJOR ☐	☐ PER PERSON ☐ PER FAMILY		

SECONDARY DENTAL INSURANCE

NAME OF INSURER	DATE OF BIRTH Y /M /D		
EMPLOYER			
INSURANCE CARRIER			
GROUP/POLICY NUMBER	DIVISION		
I.D. NUMBER OR S.I.N.			
CERTIFICATE NUMBER A ☐ B ☐ C ☐ D ☐			
LIMITS BASIC ☐ MAJOR ☐ ORTHO ☐			
DEDUCTIBLE BASIC ☐ MAJOR ☐	☐ PER PERSON ☐ PER FAMILY		

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HEATH QUESTIONNAIRE

To help ensure your well being while receiving treatment in our office, please answer the following questions. All information will be considered confidential and for our records only.

1. Have you been examined and/or treated by a physician within the last year? Physician's Name: _____ Physician's Phone: _____	☐ YES ☐ NO
2. Have you ever been seriously ill or hospitalized?	☐ YES ☐ NO
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma?	☐ YES ☐ NO
4. Are you taking any medications or non-prescription drugs now? What? _____	☐ YES ☐ NO

Please check ☑ if you have or have had any of the following?

SPECIFIC

- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Congenital heart condition
- ☐ Heart attack
- ☐ Asteriosclerosis
- ☐ Stroke
- ☐ Angina pectoris
- ☐ Blood pressure problems
- ☐ Heart troubles
- ☐ Lung/breathing problems
- ☐ Kidney/bladder problems
- ☐ Stomach/intestinal problems
- ☐ Hepatitis/jaundice
- ☐ Diabetes
- ☐ Blood disorders
- ☐ Pacemaker/artificial valves
- ☐ Artificial joints/implants
- ☐ Infectious/communicable diseases
- ☐ Venereal disease
- ☐ AIDS
- ☐ Positive testing for HIV virus
- ☐ Tumors or growths
- ☐ Nervous/mental problems
- ☐ Epilepsy
- ☐ Thyroid diesease
- ☐ Arthritis
- ☐ Inflammatory rheumatism
- ☐ Cortisone/steroid therapy

SENSITIVITIES/ALLERGIES:

- ☐ Hepatitis/jaundice
- ☐ Diabetes
- ☐ Blood disorders
- ☐ Pacemaker/artificial valves
- ☐ Artificial joints/implants

SYSTEMS REVIEW

- ☐ Prolonged bleeding after injury
- ☐ Bruise easily
- ☐ High risk group for AIDS
- ☐ Severe headaches
- ☐ Sinus trouble
- ☐ Sore throats
- ☐ Earaches
- ☐ Trouble hearing
- ☐ Shortness of breath
- ☐ Chest pains
- ☐ Swollen ankles
- ☐ Heart palpitations
- ☐ Extra pillows for sleep
- ☐ Persistent cough
- ☐ Blood in sputum
- ☐ Recent change of appetite
- ☐ Foods that you cannot eat
- ☐ Difficulty in swallowing
- ☐ Frequently indigestion/vomiting
- ☐ Feel thirsty much of the time
- ☐ Urinate more than 6 times/day
- ☐ Painful, swollen joints
- ☐ Numb/prickling sensations
- ☐ History of broken bones
- ☐ Tendency to faint
- ☐ Fits, seizures or convulsions
- ☐ History of family diesease

HABITS

- ☐ Tobacco
- ☐ Alcoholic beverages
- ☐ Non-prescription drugs
- ☐ Other

WOMEN ONLY: Are you

- ☐ Pregnant (how many months ___)
- ☐ Past menopause

Have you ever been seriously ill or hospitalized? _____	☐ YES ☐ NO

Date: _____ **Signature:** _____

☐ Patient ☐ Parent ☐ Guardian

NOTES: _____

_____

_____

MOUNT PLEASANT DENTAL GROUP

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DENTAL HISTORY

1. Date of last dental visit: _____ Former Dentist: _____ Purpose: _____	
2. Have you had regular dental care (annually) in the past?	☐ YES ☐ NO
3. Do you have any oral habits such as clenching, grinding your teeth, or nail biting?	☐ YES ☐ NO
4. Have you ever had tooth brushing instructions? How often do you brush your teeth? _____	☐ YES ☐ NO
5. Have you ever had instructions in using dental floss? How often do you floss your teeth? _____	☐ YES ☐ NO
6. Are you satisfied with the function and appearance of your teeth?	☐ YES ☐ NO

7. Have you ever had or do you now have any of the following:

- ☐ **Bridges**
- ☐ **Partial dentures**
- ☐ **Full dentures**
- ☐ **Root canal fillings**
- ☐ **Lost fillings**
- ☐ **Extractions**
- ☐ **Loose teeth**
- ☐ **Orthodontic treatment**
- ☐ **Swelling in your mouth or jaws**
- ☐ **Injuries to your face or jaws**
- ☐ **Gum treatments**
- ☐ **Surgery in your mouth**
- ☐ **Sensitive teeth**
- ☐ **Bleeding gums**
- ☐ **Sore or lumps in mouth**

8. What dental condition concerns you now? _____

_____

DENTAL HISTORY

I, the undersigned, consent to the dental treatment agreed upon and that I am responsible for payment of the corresponding fees. I understand that a possibility of complications exist for each treatment.

Date: _____ **Signature:** _____

☐ **Patient** ☐ **Parent** ☐ **Guardian**