# Ridge Square Dental

www.ridgesquaredental.ca info@ridgesquaredental.ca
167 Jolliffe Avenue • Rockwood, ON N0B-2K0 (519)856-9191

## Patient Information

**Chart#:** ____________________
FOR OFFICE USE ONLY

**Patient Name:** ____________________ (Last) ____________________ (First) ____ (MI) ____________________ (Preferred Name)

**Title:** __________ (Mr/Ms/Mrs/etc) **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

**Birth Date:** ____________ **Prev. Visit:** ____________ **Email Address:** ______________________________

**Phone:** ____________ (Home) ____________ (Mobile) ____________ (Work) ______ (Ext) **Best time to call:** ____________________

**Address:** ______________________________ (Address 1) ______________________________ (Address 2)

______________________________ (City) ______ (PV) ___-___ (Postal Code)

## Medical History

**The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.**

**When was your last medical checkup?** ____________________

**Have you ever been hospitalized for any illnesses or operations? If yes, please explain and list any complications:**

______________________________________________________________________

______________________________________________________________________

**Are you under a physician's care right now? If yes, please list your current Physician or any Specialists.**

______________________________________________________________________

______________________________________________________________________

**Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain**

______________________________________________________________________

______________________________________________________________________

**Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ***

◯ Yes ◯ No

**Do you have any prosthetic or artificial joints? *** ◯ Yes ◯ No

**Do you smoke or chew tobacco products?** ◯ Yes ◯ No

**Are you allergic to any of the following:**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Local Anesthetics ☐ Other

**List any other allergies**

______________________________________________________________________

______________________________________________________________________

**List all medications (prescription and non-prescription) including regular doses of aspirin:**

______________________________________________________________________

______________________________________________________________________

**Are you breastfeeding or pregnant?** ◯ Yes ◯ No

**Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)? If yes, please explain:**

______________________________________________________________________

______________________________________________________________________

**Do you identify as a patient with a disability?** ◯ Yes ◯ No

**Are you being treated for any medical conditions or have any allergies? Please check.**

- ☐ *Pre-Medication
- ☐ Alcohol Dependency
- ☐ Allergy
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Bulemia
- ☐ Cancer
- ☐ Cannibis Dependency
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cong. Heart Disorder
- ☐ Contraceptive Use
- ☐ Cortisone Medicine
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Epilepsy/Seizure
- ☐ Excessive Bleeding
- ☐ Excessive Bruising
- ☐ Glaucoma
- ☐ Hard To Freeze
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart valve replacem
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ HIV/AIDS positive
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Multiple Sclerosis
- ☐ Osteoporosis Meds
- ☐ Other
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Rheumatoid Arthritis
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Wheelchair

**Are there any conditions or diseases not listed above that you have or have had? If yes please explain:**

______________________________________________

______________________________________________

## Dental History

**When was your last dental office visit?**

______________________________________________

______________________________________________

**To be able to meet your individual dental needs, we would like to take a few minutes to find out more about you!**

**What motivated you to book this appointment?**

☐ Location ☐ Cosmetics Discussion ☐ Increase Function ☐ Pain Management ☐ Prevention ☐ Personal Referral

**Do you have an existing dental concern? If yes please explain.**

______________________________________________

______________________________________________

**Do you have or have you ever experienced any of the following?**

☐ Dry mouth ☐ Bad breath ☐ Bleeding gums ☐ Sensitive teeth (hot or cold)
☐ Sore jaw ☐ Difficulty chewing

**On a scale of 1-5, how happy are you with your smile?**

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

**Are you nervous during dental treatment?** ○ Yes ○ No

**Sometimes there are barriers to accomplishing dental work. There are many ways we can help. Please check any that concern you.**

☐ Time ☐ Cost ☐ Fear ☐ Trust

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

**Patient's Signature**

---

**Response Date:** ____________