



NEW PATIENT FORM

Medical/Dental History (Adult)

How to return this form. Open this form in Adobe Acrobat Reader (free) to type your answers, then save it and email it to info@lunarsmiledentistry.ca. You can also print it and bring it to your first visit. Questions? Call us at 226-884-2573.

About you

Title	First name	Last name	Preferred name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth (YYYY-MM-DD)	Age	How did you hear about us?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Gender: ☐ Male ☐ Female ☐ Another gender ☐ Prefer not to say			
Street address	City	Province	Postal code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mobile phone	Home phone	Work phone	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Email	Occupation	Employer	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Best way to reach you: ☐ Phone call ☐ Text message ☐ Email			

Family doctor and emergency contact

Family doctor	Doctor's phone	
<input type="text"/>	<input type="text"/>	
Emergency contact name	Relationship	Emergency contact phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

If the patient is under 18

Parent / guardian 1 name	Parent / guardian 1 phone
<input type="text"/>	<input type="text"/>
Parent / guardian 2 name	Parent / guardian 2 phone
<input type="text"/>	<input type="text"/>
Person responsible for the account	
<input type="text"/>	

Medical history

1. Are you being treated for a medical condition now, or have you been in the past year? ☐ Yes ☐ No

If yes, please explain



2. When was your last medical checkup?

3. Has your general health changed in the past year?

☐ Yes ☐ No

If yes, please explain

4. Do you take any prescription or non-prescription medications, vitamins or herbal supplements?

☐ Yes ☐ No

If yes, please list each one and the dose

5. Do you have any allergies?

☐ Yes ☐ No

If yes, please list them (e.g. medications, latex, foods, other)

6. Have you ever had an unusual or bad reaction to a medication or injection, including dental freezing?

☐ Yes ☐ No

If yes, please explain

7. Do you have, or have you had, asthma?

☐ Yes ☐ No

8. Do you have, or have you had, heart or blood pressure problems?

☐ Yes ☐ No

9. Do you have an artificial heart valve, a heart condition you were born with, or a heart transplant, or have you ever had an infection of the heart (infective endocarditis)?

☐ Yes ☐ No

If yes, please explain

10. Do you have an artificial (replacement) joint?

☐ Yes ☐ No

If yes, which joint and when was it placed?

11. Do you have a condition or treatment that weakens your immune system (e.g. leukemia, HIV, chemotherapy, radiation)?

☐ Yes ☐ No

12. Have you ever had hepatitis, jaundice or liver disease?

☐ Yes ☐ No

13. Do you have a bleeding disorder, or do you take blood thinners?

☐ Yes ☐ No

14. Have you ever been in hospital for an illness or surgery?

☐ Yes ☐ No

If yes, please explain



15. Please check any of the following you have now or have had in the past:

- | | | |
|--|---|--|
| ☐ Chest pain / angina | ☐ Heart attack | ☐ Heart murmur |
| ☐ Mitral valve prolapse | ☐ Pacemaker | ☐ Rheumatic fever |
| ☐ Shortness of breath | ☐ Lung disease | ☐ Tuberculosis |
| ☐ Stroke | ☐ Seizures / epilepsy | ☐ Diabetes |
| ☐ Thyroid disease | ☐ Kidney disease | ☐ Stomach ulcers |
| ☐ Arthritis | ☐ Cancer | ☐ Steroid therapy |
| ☐ Osteoporosis medication | ☐ Drug or alcohol dependency | |

16. Do you have, or have you had, any other condition or illness not listed above?

☐ Yes ☐ No

If yes, please explain

17. Do any illnesses run in your family (e.g. diabetes, cancer, heart disease)?

☐ Yes ☐ No

If yes, please explain

18. Do you smoke, vape, or use tobacco or cannabis?

☐ Yes ☐ No

If yes, what and how often?

19. Do you feel nervous about dental treatment?

☐ Yes ☐ No

Is there anything that would help you feel more comfortable?

20. If applicable:

Are you pregnant?

☐ Yes ☐ No

If yes, how many weeks?

Are you breastfeeding?

☐ Yes ☐ No

Are you taking birth control pills?

☐ Yes ☐ No

Dental history

1. When was your last dental visit, and what was it for?

2. How often do you see a dentist?

3. How often do you brush?

4. How often do you floss?

5. Do any of these cause tooth discomfort? ☐ Cold ☐ Heat ☐ Sweets ☐ Biting / chewing

6. Do you have a dental problem that needs attention right away?

☐ Yes ☐ No

If yes, please explain



7. Do your gums bleed when you brush or floss? ☐ Yes ☐ No
8. Have you noticed any loose teeth? ☐ Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes ☐ No
If yes, do you wear a night guard?
10. Have you been diagnosed with sleep apnea, or do you snore? ☐ Yes ☐ No
If yes, do you use a CPAP machine or oral appliance?
11. Have you had orthodontic treatment (braces or clear aligners)? ☐ Yes ☐ No
12. I would like to learn more about: ☐ Straightening ☐ Whitening ☐ Veneers ☐ Crowns
☐ Implants
13. Have you had any problems or complications with past dental treatment?
14. Is there anything else about your dental history you would like us to know?

Dental insurance

Do you have dental insurance? ☐ Yes ☐ No

Are you covered by the Canadian Dental Care Plan (CDCP)?

☐ Yes ☐ No

Primary dental insurance

Insurance company	Group / policy number	ID / certificate number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Policy holder name	Policy holder date of birth	Relationship to patient	Policy holder employer
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Secondary dental insurance

Insurance company	Group / policy number	ID / certificate number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Policy holder name	Policy holder date of birth	Relationship to patient	Policy holder employer
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



Cancellations and missed appointments

Your appointment time is set aside just for you. If you need to cancel or reschedule, please give us at least 48 hours notice so we can offer the time to another patient. Appointments cancelled with less than 48 hours notice, and missed appointments, are subject to a \$50 fee, payable before your next appointment.

Agreement and signature

Please tick each statement to confirm it is true for you.

- ☐ The personal, medical and dental information I have given is accurate and complete, and I have not knowingly left anything out.
- ☐ I will tell the office if my health or any of this information changes.
- ☐ I have had the chance to ask questions about my medical and dental history.
- ☐ I authorize the dentist to carry out the examinations and diagnostic records needed to plan my care, such as x-rays and photographs, and to provide treatment that I agree to.
- ☐ I understand that information may need to be shared with my physician or other health care providers involved in my care.
- ☐ I have been told about the office's privacy policy, and I understand how my personal information is collected, used and shared.
- ☐ I understand that insurance may not cover the full cost of my care, and that I am responsible for payment for myself and my dependants.

Signed by: ☐ Patient ☐ Parent ☐ Legal guardian ☐ Substitute decision-maker

Full name of person signing

Relationship (if not the patient)

Email

Signature

X

Date (YYYY-MM-DD)

Sign with the Fill & Sign tool in Adobe Acrobat Reader, or print this page and sign by hand.