NEW PATIENT INTAKE FORM

Patient Name:

☐Male
☐Female

First | Last | Birth Date (DD/MM/YYYY)

Email Address | Phone ☐Home ☐Work (Ext) ☐Mobile

What is the best way for us to reach you? ☐Phone ☐Email

Best time to call

Street Address | City | Province | Postal Code

Provincial Health Card Information (Province/Number)

Emergency Contact Name

How did you hear about us?

☐Google
☐Signage
☐Social Media
☐Website
☐Friend/Family/Word of Mouth
☐Other

Emergency Contact Number:

Who referred you? (We'd love to learn how you heard about us!)

MEDICAL HISTORY

How would you describe your general health?
☐Good ☐Fair ☐Poor

Family Physician Name _____ Family Physician Contact Information _____

Preferred Pharmacy (if applicable) _____

PLEASE CHECK OFF ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU.

☐ Allergy. If yes, please list:

_____

☐ Acid Reflux
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorder
☐ Pacemaker
☐ Blood disorder, such as anemia
☐ Cancer/Tumors
☐ Diabetes
☐ Heart condition
☐ High/Low Blood Pressure
☐ Chest Pains
☐ HIV/AIDS
☐ Hives or skin rash
☐ Fainting spells, seizures, or epilepsy
☐ Cold sores
☐ Kidney disease
☐ Lung Disease
☐ Mental health challenges
☐ Osteoporosis
☐ Rheumatic Fever
☐ Sinus Trouble
☐ Shortness of breath
☐ Stroke
☐ Stomach ulcers
☐ Thyroid Disease
☐ Ulcers
☐ Cardiovascular disease (Heart attack, coronary occlusion, coronary insufficiency, arteriosclerosis)
☐ Hepatitis A/B/C
☐ Jaundice, or liver disease
☐ Heart valve replacement or pathology

☐ Are you pregnant? If so, expected delivery date: _____

☐ Are you breastfeeding?
☐ Are you taking contraceptives or hormones?

QUESTIONS

What medications are you currently taking (prescription or non-prescription)?

Are you under the care of a physician for a specific chronic condition? If so, please specify condition:

Date of last check-up (DD/MM/YYYY)

Do you smoke, chew tobacco products, or vape? If yes, how often? For how long?

Do you have a prosthetic or artificial joint? If so, please list:

Have you had any major surgeries in the last two years? ☐ Yes ☐ No

Does your mouth frequently become dry? ☐ Yes ☐ No

Have you experienced numbness or tingling in any part of your body? ☐ Yes ☐ No

Do you bruise easily? ☐ Yes ☐ No

Do you vape? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Do you participate in social drug use? ☐ Yes ☐ No

Do your ankles swell? ☐ Yes ☐ No

Do you suffer from frequent headaches or spells of dizziness? ☐ Yes ☐ No

Have you traveled out of the country within the last 6 months? ☐ Yes ☐ No

If Yes, where? _____

Do you have any other health conditions we should be aware of that are not listed above?

DENTAL HISTORY

Name of Previous Dentist _____ Previous Dentist Contact Information _____

Have you had any abnormal bleeding associated with previous dental work (extractions, surgery, or trauma)? ☐Yes ☐No

When were your last dental x-rays taken? _____

Would you like your previous dental x-rays transferred to Norwood Dental from your previous dental office? ☐Yes ☐No

How would you describe yourself as a dental patient ?

Calm ☐ Somewhat Anxious ☐ Very Anxious ☐

Have you noticed any of the following:

☐ Bleeding/swelling gums ☐ Jaw Pain/Noise ☐ Receding Gums
☐ Gum Ache ☐ Loose/Drifting Teeth ☐ Tooth Sensitivity

Is there anything else we should know about before treating you?

PATIENT AUTHORIZATION

I hereby certify that I have provided an accurate and complete medical-dental history, and have not knowingly omitted any information. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the dentist to contact my medical doctor for further information on my health if necessary. In addition, I consent to the collection, use, retention, and disclosure of my personal information as is required for my, and that of my dependents, dental care.

Name	Signature	Date (DD/MM/YYYY)

Relationship to Patient (check off): Self ☐ Guardian ☐ Parent ☐

At Norwood Dental Centre, each patient is important and treated with care, comfort, and kindness. Our goal is to put you at ease and provide quality oral care consistent with your needs and budget.

Thank you for being our patient!