DENTISTRY IN OAK PARK

Dr. Margaret Plewik & Associates

Welcome to our dental office. Your cooperation in filling out the data on this confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office. Please feel tree to ask receptionist for help in completing this form.

I. Personal Information (please print) **Date** ____/_____/_____ D M Y

Dr.☐ Mr.☐ Mrs.☐ Ms.☐ Mas.☐ Miss.☐

Name _____
(Last) (First) (Initial)

Address _____
(Street) (Apt.)

_____
(City) (Prov.) (Postal Code)

Telephone: Cell_____ **Res.** _____**E-mail** _____**Bus.** _____

Date Of Birth ____/_____/_____ **Age** _____ **Marital Status**_____
D M Y

Employed by _____**Occupation** _____

Personal Physician _____ **Phone** _____**E-mail**_____

Person responsible for account: Self ☐ Spouse _____**Other** _____

Whom may we thank for referring you? _____

Dental Insurance: Yes ☐ No ☐ Name of Insurance Company_____

Group Policy No. _____**I.D. No.**_____ **% Covered**_____

In case of emergency please notify_____
(Name) (Relationship) (Phone)

II. Medical History	**Yes**	**No**
1. Are you presently in good health?	☐	☐
2. Are you presently under care of a physician?	☐	☐
If so, explain _____		
3. Have you ever had a serious illness or operation or been hospitalized?	☐	☐
Specify: _____		
4. Are you taking any medicine or drugs at the present time?	☐	☐
If so, please list ALL medications currently taken:		
A) DRUG _____ REASON _____ D) DRUG _____ REASON _____		
B) DRUG _____ REASON _____ E) DRUG _____ REASON _____		
C) DRUG _____ REASON _____ F) DRUG _____ REASON _____		
5. Are you taking ANY FORM of Aspirin, including "baby Aspirin" ?	☐	☐
6. Are you taking any medication for OSTEOPOROSIS ?	☐	☐
If so, specify: _____		
7. Have you taken any prolonged medication in the past, prescription or non-prescription?	☐	☐
If so, specify: _____		
8. Do you bruise easily or have prolonged bleeding?	☐	☐
9. Have you ever had a reaction to any kind of medicine?	☐	☐
If so, specify: Penicillin☐ Codeine☐ Aspirin☐ Other_____		
10. Have you been warned against taking any drug or medicine?	☐	☐
11. Do you smoke? If so how much? _____		
12. Have you ever fainted?	☐	☐
13. Are you on any special diet?	☐	☐
14. Do you have any allergies?	☐	☐
If so, specify: _____		
15. WOMEN: Are you pregnant? If so, what month?_____		
Are you taking any birth control pills?	☐	☐
16. Is there any history of family disease e.g. heart problems, diabetes, ect.?	☐	☐

17. Have you ever had any injury, surgery or X-ray therapy on your face or jaws? ..... ☐ ☐

18. Have you ever had local anaesthetic (freezing)? ..... ☐ ☐

Any complications? Yes☐ No☐ Specify: _____

19. Do you have or have you ever had:

☐ Arthritis	☐ AIDS/HIV+	☐ Asthma	☐ Blood Disorder	☐ Bulimia / Anorexia Nervosa
☐ Cancer	☐ Diabetes	☐ Stroke	☐ Epilepsy	☐ Stomach / Intestinal Problems
☐ Heart Attack	☐ Heart Murmur	☐ Heart Disease	☐ Heart Prosthesis	☐ High / Low Blood Pressure
☐ Pace Maker	☐ Cardiac Arrythmia	☐ Heart Surgery	☐ Hip Replacement	☐ Knee Replacement
☐ Kidney Disease	☐ Liver Disease	☐ Lung Disease	☐ Thyroid Problems	☐ Mental or Nervous Disease
☐ Tuberculosis	☐ Venereal Disease	☐ Rheumatic Fever	☐ Joint Prosthesis	☐ Hepatitis or Jaundice
☐ Radiation or Chemotherapy		☐ Sinus Problems		

20. Is there anything that the Doctor should know regarding your medical history that has not been mentioned? ..... ☐ **Yes** ☐ **No**

If so, specify: _____

III. Dental History

1. When was your last dental visit?_____

2. How often do you have a dental check-up? ☐ **months** ☐ **yearly** **other** _____

3. What kind of dental work have you had in the past?

☐ **Cleanings** ☐ **Filings** ☐ **Caps** ☐ **Bridges** ☐ **Partial or Full Dentures** ☐ **Root Canal**

☐ **Orthodontics** ☐ **Periodontal (gum) Treatment** ☐ **Extractions** ☐ **Implants**

4. Are you using any removable dental appliance?

☐ **Ortho Retainer** ☐ **Removable Partial Denture** ☐ **Removable Complete Denture** ☐ **Nightguard**

☐ **Sportsguard**

	Yes	No
5. Have you ever had an unfavourable experience at the dentist?	☐	☐
6. Are any of your teeth sensitive to: ☐ **cold** ☐ **hot** ☐ **sweets** ☐ **biting**		
7. Does food catches between your teeth? _____ **If so, where?** _____		
8. Do your gums bleed when brushing or flossing?	☐	☐
9. Do you suffer from pain and/or swelling of your gums?	☐	☐
10. Are you conscious of bad breath or a bad taste in your mouth?	☐	☐
11. Do you favour one side when chewing?	☐	☐
12. Are you unhappy with the appearance of your teeth, bite or smile?	☐	☐
13. Do you gag easily?	☐	☐
14. Do you ever wake up with the headache or have a tired feeling in your face or jaws?	☐	☐
15. Do your jaw joints pop, click or grate when opening widely?	☐	☐
16. Do you clench or grind your teeth?	☐	☐
17. Have you lost any teeth due to: ☐ **abscess** ☐ **accident** ☐ **decay** ☐ **gum disease**		
18. If you have crowns, bridges or removable dentures – give approximate time of insertion _____		
_____		
19. Are you tense during dental visits?	☐	☐
20. How often do you: brush _____ **floss** _____		
use any mouthwash _____		

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions I regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary. I understand that responsibility for payment for the dental services for myself or my dependants is mine, and I will assume all responsibilityfor fees associated with these services.

_____

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