Bramdale DENTAL OFFICE

Address: 6900 Peter Robertson Blvd #12, Brampton, ON L6R 1A2
E-mail: info@bramdaledental.com
Ph: 905-790-2345

NEW PATIENT FORM

Patient Information

Name

Address

City

Province

Postal Code

Home Tel

Cell

Email

Sex

Date Of Birth

Occupation

Employed by

Notify in case of emergency

Home Phone

Cell Phone

Business Phone

E-mail

Medical History

Family Doctor's Name

Phone

Are you currently under medical care ? ☐ Yes ☐ No

Have you ever had serious illnesses or surgeries in the past? ☐ Yes ☐ No

Have you ever taken Fen-Phen / Redux? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever used a bisphosphonate? ☐ Yes ☐ No

(Bisphosphonates are a class of drugs that prevent the loss of bone density, used to treat osteoporosis and similar diseases. They are the most commonly prescribed drugs used to treat osteoporsis.)
Copied from google

Females: Are you pregnant? ☐ Yes ☐ No

Females: Are you nursing? ☐ Yes ☐ No

Females: Are you on birth control pills? ☐ Yes ☐ No

Have you ever had any of these conditions (Check)

- ☐ Epilepsy
- ☐ Asthma
- ☐ Allergy
- ☐ Stroke
- ☐ Arthritis
- ☐ Herpes
- ☐ Anemia
- ☐ Smoking
- ☐ TB
- ☐ Tonsillitis
- ☐ Glaucoma
- ☐ Shingles
- ☐ Cancer (Type)
- ☐ Diabetes (Type)
- ☐ AIDS/HIV Positive
- ☐ Chemotherapy
- ☐ Heart Problems
- ☐ Surgical Implants
- ☐ Blood disease
- ☐ Artificial joint
- ☐ Liver disease
- ☐ Kidney problems
- ☐ Latex allergy
- ☐ Ulcerative Colitis
- ☐ Psychiatric care
- ☐ Rapid weight change
- ☐ Radiation treatment
- ☐ Lung disease
- ☐ Shortness of breath
- ☐ Spine bifida
- ☐ Headache
- ☐ Artificial heart valve
- ☐ Leg swelling
- ☐ Thyroid disease
- ☐ Anaphylaxia
- ☐ Neurologic problems
- ☐ Venereal disease
- ☐ Cortisone treatment
- ☐ Coughing blood
- ☐ Rheumatic fever
- ☐ Blood pressure (High)
- ☐ Blood pressure (Low)

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NEW PATIENT FORM

Dental History

What would you like done today?

Do you have a dental pain (please specify)?

Former Dentist | Email | Phone

Address

Date of last dental care | Date of last X-ray

Have you ever had any of these conditions (Check all that apply)

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Hot sensitivity
- ☐ Cold sensitivity
- ☐ Sweet sensitivity
- ☐ Biting sensitivity
- ☐ Mouth growths/sores
- ☐ Periodontal treatment
- ☐ Grinding/clenching teeth
- ☐ Loose teeth/broken filling
- ☐ Clicking/popping jaw
- ☐ Food in between teeth

How regularly do you brush your teeth? Quantity please?

How do you feel about your teeth?

Have you ever had an adverse reaction related to a medical/dental procedure? If yes, please describe:

Other pertinent information about your dental health:

Authorization

I have reviewed the information in this questionnaire. To the best of my knowledge, this information is accurate. I understand that this information can be used by my dentist to determine appropriate and healthful dental treatments. I understand that i have to declare any change in my medical status.

I authorize the insurance company to pay the dentist all insurance benefits otherwise payble to me for serviceds rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that i an financially responsible for all charges whether or not paid by my insurance.

Signature | Date