5-8550 Torbram Rd.,
Brampton, ON L6T 5C8

www.torbramdental.com
info@torbramdental.com

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PLEASE PRINT

PERSONAL INFORMATION			
Surname Given Name Middle Initials			Preferred Name
Home Address APT# City		Prov.	Postal Code
Home Phone Cell Phone		E-mail:	
Date of Birth Age		Male or Female	Marital Status
Drivers Licence #		SIN#	
Occupation Employer		Work Phone	OK To Call Work ( )Yes ( ) No
Spouse's Occupation Spouse's Employer		Work Phone	OK To Call Work ( )Yes ( ) No
Person we can contact in case of emergency (other than your family home) Name Relationship		Work Phone	Home Phone
Other family members under our care			
Who can we thank for inviting you to our office?			
DENTAL BENEFITS			
Primary Dental Benefits ( )Yes ( )No	Insurance Carrier	Subscriber Name	Employer of Subscriber
Subscriber Date of Birth		Relationship to Subscriber	
Group/Policy Number		Certificate/I.D. Number	
Secondary Dental Benefits ( )Yes ( )No	Insurance Carrier	Subscriber Name	Employer of Subscriber
Subscriber Date of Birth		Relationship to Subscriber	
Group/Policy Number		Certificate/I.D. Number	

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize Dr. Fava and Associates to perform necessary diagnostic procedures and treatment. I understand that I am financially responsible for the dental services provided even if my insurance coverage may not be all-inclusive.

My preferred method of payment for services is ( ) CASH ( ) CHEQUE ( ) INTERAC ( ) CREDIT CARD

_____ _____

Date Patient/Guardian Signature

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MEDICAL HISTORY

Name		Date
PRESENT MEDICAL CARE		
Name of Family Doctor	Phone	Date of Last Physical Examination
Estimate of General Health	( ) Poor ( ) Fair ( ) Good ( ) Excellent	

PLEASE CHECK YES OR NO

GENERAL INFORMATION	**Yes**	**No**	**REASON**
Are you **presently** under a doctor's care?			
Have you been under doctor's care for last 2 years?			
Are you **presently** taking any medications or drugs?			
Have you taken any medications or drugs in the last 2years?			
Have you been hospitalized?			
Have you had any type of surgery?			
Do you take antibiotics before dental treatment?			
History of head or neck injury?			
Alcohol or drug dependency?			
Do you smoke?			

HAVE YOU EXPERIENCED AN ALLERGIC OR ADVERSE REACTION TO:	**Yes**	**No**	**MEDICAL CONDITONS**	**Yes**	**No**
Asprin, Ibuprofen, Advil or any NSAID			Tonsillitis, Scarlet Fever		
Acetaminophen, Tylenol			Rheumatic Fever		
Codeine, Tylenol #1, #2, #3, #4			Heart Murmur		
Penicillin, Amoxicillin			Artificial Heart Valves		
Erythromycin			Heart Pacemaker		
Tetracycline, Doxycycline			Mitral Valve Prolapse		
Clindamycin			Angina, Chest pains		
Fluoride			History of Heart Attack		
Nitrous Oxide (Laughing Gas), Valium			History of Stroke		
Chlohexidine			High Blood Pressure		
Sulpha Drugs			Low Blood Pressure		
Local Anaesthetics (Numbing/Freezing)			Anemia or Blood Disorder		
Latex			Bleeding Disorder		
Metals (gold, nickel, silver)			Artificial Joints		
Have you had any other not listed?			Asthma		
MEDICAL CONDITIONS			Lung Disease (COPD)		
Psychiatric Care			Kidney Disease		
Glandular Disorders			Liver Disease/Jaundice		
Cancer/Tumours			Thyroid/Parathyroid Disease		
Radiation/Chemotherapy			History of Ulcers		
HIV or Hepatitis Exposure			Stomach/Intestinal Disorders		
Venereal Diseases/Herpes			Glaucoma/Eye Disorders		
WOMEN ONLY			Diabetes or Hypoglycemia		
Are you pregnant? How far along?			Arthritis		
Are you nursing?			Epilepsy/Seizures		
Are you taking birth control pills			Fainting/Dizziness		

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Are you taking fertility drugs?					

DENTAL HISTORY

PAST DENTAL CARE		
Name of Previous Dentist	Last Dental Cleaning	Last Dental Exam and X-rays
WHAT IS YOUR IMMEDIATE DENTAL CONCERN?		

PLEASE CHECK YES OR NO

GENERAL INFORMATION	**YES**	**NO**	**SMILE CONCERNS**	**YES**	**NO**
Do you have any pain presently?			Are you happy with your smile?		
Are you aware of any sores in your mouth?			....The colour of your teeth?		
Do you avoid brushing/flossing certain areas?			....Shape or position of your teeth		
Are your teeth sensitive? ( )cold ( )hot ( )pressure/biting ( )sweets			Are you interested in exploring treatment options presently?		
Does food get caught between your teeth?			**TMJ/BITE PROBLEMS**		
Have you ever had local anaesthetic/freezing?			Does you joint(s) pop or click?		
....Any complications?			Pain/sore in joints or muscles?		
Have you had teeth extracted?			Awaken with sore teeth?		
....Any complicaitons?			Clench or grind your teeth?		
Aware of any burning sensation in your mouth?			Difficulty in opening mouth wide?		
Does your mouth tend to get dry?			Wear a prescribed nightguard?		
Do you have difficulty swallowing?			Surgery in your jaw joints?		
Are any teeth loose for shifting?			Seen by a dental specialist?		
Do you have a family history of gum disease?			**PAST DENTAL TREATMENT**		
Do you have an unpleasant odor or taste in your mouth?			Orthodontics (braces)		
Are you anxious of dental treatment?			Periodontal (Gum) Treatment		
....Is sedation for treatment needed?			Periodontal Surgery		
Have you ever had an unpleasant dental visit?			Oral Surgery (Wisdom Teeth)		
HOME CARE &ORAL HYGIENE ROUTINE			Bite/Teeth adjusted		
How often do you brush?			Dental Implants		
How often do you floss?			Root Canal Therapy		
Do you use a mouth rinse routinely?			Snoring/Sleep Apnea		
Do you use any other dental hygiene aids?			Nightguard or other appliance		
Do you hold/chew foreign objects with your teeth?			Sedation		
Do you bite your nails?			Crowns		

SUPPLEMENTAL DENTURE HISTORY--*Complete if you wear a denture*
When did you receive your first denture?
Has it been relined or replaced?
How long have you worn your present denture?
Is your present denture a problem?
Are you satisfied with the stability and chewing ability?
Are you satisfied with the appearance?