SUTER BROOK
DENTAL GROUP

Welcome to the family!

We are thrilled to have you as a patient at Suter Brook Dental Group and want to ensure your experience with us is unforgettable. To help us understand how to meet your specific treatment goals, please fill out these questions so we can know you better.

THE NECESSITIES:

Your full name _____ How you'd like to be addressed _____

Your gender _____ Male _____ Female _____ Prefer not to specify

Your birthdate _____ Under 18? Please provide a guardian name & contact _____

Street address _____ City _____ Province _____ Postal code _____

Email address _____ Instagram/FB (optional) @_____

Your emergency contact name & number _____

Whom may we thank for referring you to our office? _____

THE STORY OF YOUR MOUTH:

- What brings you to our office today? _____
- When was your last dental visit and what work, if any, was done? _____
- There are 5 reasons why a person resists going to the dentist; are any of these a factor and if so choose the one that is most important:

____ Fear (on a scale of 1-10) ____ Time ____ Budget ____ Trust ____ No sense of urgency ____ N/A

Although all of the following are important to your oral health, which one of these is the most important to you?

☐ Cosmetic ☐ Function ☐ Comfort ☐ Longevity

- If you could change anything about your smile, what would it be?_____
- How often do you brush your teeth? _____ How often do you floss your teeth?_____

Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
Are your teeth sensitive to hot/cold liquids or foods?	☐ Yes	☐ No
Do you feel pain in any of your teeth?	☐ Yes	☐ No
Does food tend to get caught between your teeth?	☐ Yes	☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Do you bite your lips, cheeks and/or tongue frequently?	☐ Yes	☐ No
Have you noticed any loosening or movement of any of your teeth?	☐ Yes	☐ No
Do you suffer from having a dry mouth?	☐ Yes	☐ No
Have you ever had radiation treatment to the face and/or neck?	☐ Yes	☐ No
Have you had any complications with dental extractions in the past?	☐ Yes	☐ No
Have you ever experienced any of the following problems in your jaw – clicking, pain (joint, ear, side of face, difficulty in opening or closing, difficulty in chewing)?	☐ Yes	☐ No
Do you have frequent headaches?	☐ Yes	☐ No
Do you snore at night?	☐ Yes	☐ No
Do you experience restless sleep and/or feel drowsy when you start your day?	☐ Yes	☐ No

In the past, have you ever had:

- Orthodontic treatment? If so, how old were you? _____
- Periodontal treatment (gums)? Describe what you had done _____

_____

MEDICAL HISTORY:

- Are you in good health? ☐ Yes ☐ No
- Have there been any changes in your health within the past year? If yes, please explain

_____

- Physician's name, address & phone number_____

Date of your last physician exam _____

- Are you currently under the care of a physician or any other health care professional (naturopath, RMT, chiro)? If so, who? And for what purpose?_____
- Have you ever been hospitalized for any surgical operations or serious illnesses. If yes, please explain

_____

_____

- Are you taking any medication(s) including non-prescription medicine such as vitamins/supplements. This information is confidential and helps us avoid potentially dangerous drug interactions. Please list here, including dosages:

_____

- Do you have any allergies?_____
- Have you had any abnormal bleeding in the past? ☐ Yes ☐ No • Do you bruise easily? ☐ Yes ☐ No
- Have you had any recent weight loss or gain? Please explain _____
- Do you smoke cigarettes, marijuana or chew tobacco? Circle which one(s), and report how much and how often?

_____

- Do you, or have you, had a dependency on controlled substances? When and which one(s)? _____
- Are you pregnant or possibly pregnant? ☐ Yes ☐ No • Are you nursing? ☐ Yes ☐ No
- Are you taking birth control pills? ☐ Yes ☐ No
- Please check if you have or have had any of the following. If yes, please elaborate on the condition, treatment/medications used for each:

☐ Cardiovascular disease (high cholesterol, stroke, heart attack, congenital defects, artificial valves etc)

_____

☐ Lung disease (asthma, COPD, etc) _____

☐ Liver disease (Hepatitis, fatty liver, cirrhosis, etc) _____

☐ Kidney Disease (Stones, decreased GFR, etc) _____

☐ Neurological (Epilepsy, MS, etc) _____

☐ Muscular Disease (Muscular dystrophy, ALS, myasthenia gravis, etc) _____

☐ Hormonal Disturbances (menopause, etc) _____

☐ Mental Health Disease (anxiety, depression, bipolar, schizophrenia etc) _____

☐ Gastrointestinal Disease (acid reflux, ulcers, Crohn's, UC, pancreatitis, etc) _____

☐ Endocrine Disorders (Hypo/Hyper-Thyroid, adrenal insufficiency, diabetes type II, etc) _____

☐ Autoimmune Disease (Diabetes type I, Sjogren's, lupus, HIV/AIDS etc) _____

☐ Bleeding disorders (VWD, hemophilia, etc) _____

☐ Skeletal/Arthritic Conditions (ost eoporosis, etc) _____

☐ Skin Disease (psoriasis, rosacea, eczema, etc) _____

☐ Tumours (benign or malignant) and cancer _____

- Do you have a pacemaker? ☐ Yes ☐ No
- Do you have any prosthetic joints? If yes, which one(s) _____
- Have you ever taken bisphosphonates? If so, for how long? _____
- Have you ever suffered a head, neck or jaw injury? What happened? _____
- Are you known to get frequent cold sores? ☐ Yes ☐ No • Do you have a sensitivity to latex products? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Doctor Signature: _____