

PERSONAL INFORMATION (Please Print)

DATE:
D M Y

(GIVENNAME) (MI) (FAMILY NAME) (NICKNAME)

Address: _____
(NUMBER) (STREET) (APT.)

(CITY) (PROV) (POSTAL CODE)

Date of Birth: Gender: Female Male AGE: _____
D M Y Place of Birth _____

Telephone: Residence: _____ Business: _____ Ext: _____
Cell: _____ E-mail: _____

Occupation: _____ Place of Business: _____

Referred by: _____

Person responsible for account: Self Other _____

Dental Insurance: Yes No If Yes, Insurance Name: _____

Group #: _____ ID #: _____ Subscriber Name: _____ DOB:
D M Y

Physician Name: _____ Telephone: _____

In case of emergency, please notify: Name _____

Relationship: _____ Telephone: _____

Additional Personal Information: _____

I understand the fees charged for many of the procedures performed are greater than the current Ontario Dental Association fee guide and are based on the degree of skill, care and judgement required.

Patient Signature _____ Date: _____

If patient is under 18 years of age: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 27. arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to _____ | <input type="checkbox"/> | <input type="checkbox"/> | 28. autoimmune disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | (i.e. rheumatoid arthritis, lupus, scleroderma) | | |
| <input type="checkbox"/> penicillin | | | 29. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulfa | | | 32. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. neurologic disorders (ADD/ADHD, prion disease) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 35. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 37. STI / STD / HPV _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. orthopedic implant (joint replacement) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. chemotherapy, immunosuppressive medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. emotional difficulties _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | 46. alcohol / recreational drug use _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 13. emphysema, shortness of breath, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 47. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis, measles, chicken pox _____ | <input type="checkbox"/> | <input type="checkbox"/> | 48. aware of a change in your health in the last 24 hours | | |
| 15. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | (i.e. fever, chills, new cough, or diarrhea) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking medication for weight management _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 50. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 51. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | 52. experiencing frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 53. a smoker, smoked previously or use smokeless tobacco _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 54. considered a touchy / sensitive person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | 55. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 56. taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | 57. currently pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders (i.e. celiac disease, gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 58. prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
 (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ YES NO
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma? _____ YES NO

GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? _____ YES NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
10. Is there anyone with a history of periodontal disease in your family? _____ YES NO
11. Have you ever experienced gum recession? _____ YES NO
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ YES NO
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ YES NO

TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? _____ YES NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ YES NO
18. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
20. Do you frequently get food caught between any teeth? _____ YES NO

BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together? _____ YES NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ YES NO
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed? _____ YES NO
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ YES NO
26. Are your teeth developing spaces or becoming more loose? _____ YES NO
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____ YES NO
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ YES NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
30. Do you clench or grind your teeth together in the daytime or make them sore? _____ YES NO
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____ YES NO
32. Do you wear or have you ever worn a bite appliance? _____ YES NO

SMILE CHARACTERISTICS



33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____ YES NO
34. Have you ever whitened (bleached) your teeth? _____ YES NO
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES NO
36. Have you been disappointed with the appearance of previous dental work? _____ YES NO

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

As of January 1st, 2004, the law is changing. Canadian federal legislation in the form of the PERSONAL INFORMATION PROTECTION ELECTRONICS DOCUMENT ACT (PIPEDA) requires us to confirm that we have your consent to the collection, use and disclosure of your personal information. We have developed a privacy policy to ensure our personal information management policies comply with privacy laws.

To continue to use or disclose the information you have already provided to us or that you will provide in the future for the provision of dental services, we need to have you confirm that we have your consent.

Please review the attached document and return this signed copy for our records.

Thank you for your co-operation.

Patient Consent (For Collection, Use and Disclosure of Personal Information)

I have read the attached information that explains how and why your office will use my personal information, and the steps your office is taking to protect my information. I know your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Dr. Dana Colson and her staff can collect, use and disclose personal information about _____ as set out in the information about the office's privacy policies.

Signature

Print Name

Date

Witness Signature





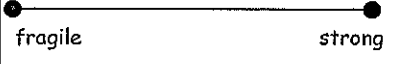
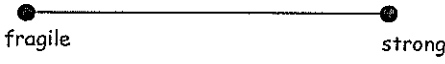

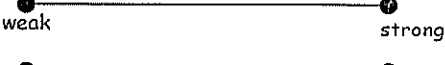





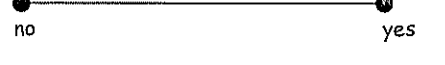


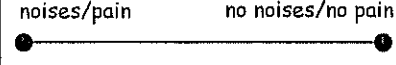
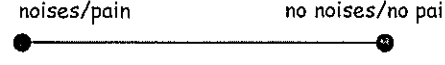

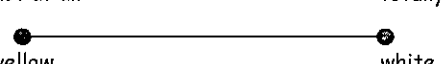


"Health" and "Healthcare"

In today's world, Health and Healthcare are confusing terms. This process covers 3 different types of care. The Healthcare system could be redefined to include three separate levels of care. Then, all the present models of "Healthcare" can be understood and appreciated.

- I- **CRISIS CARE** - emergency situations
- II- **SYMPTOM CARE** - maintaining oneself where one can "feel better", however often the real cause can go undetected until it becomes a crisis.
- III- **WELLNESS HEALTH CARE** - examining how our system may function at its optimal level. Usually this is asymptomatic care and the doctor needs to use other objective measures to determine status and results. (lab tests, posture, etc.)

Your Health Model

This graph is for us to help understand and enable you to achieve your goals. Please mark an "X" on the following lines. At any time you are welcome to change these markings.

	Where do you see yourself today?	Where would you like to be? By when? _____
Personal Wellness		
Physical Body		
Emotional		
Energetic		
Immune system		
Nutrition		
Dental Wellness		
Comfort with function of teeth and restorations		
Healthy gum tissues		
Jaw jt		
Happiness with your smile		
Colour		

Signature _____ Date _____