TMJ & Sleep Therapy Centre of Auckland

PATIENT INFORMATION

Patient Code_____

In order to render an optimum health service, it is necessary to obtain a variety of vital personal information. All information obtained is kept strictly confidential. Please print all information.

Biographical Data

Name _____ Preferred Name_____

Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Birth date (D/M/Y)_____/_____/_____ Age_____

Address_____ City, Province_____

Postal Code_____ Email_____

Address_____

Home Phone_____ Business Phone_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Occupation_____ Employer_____

Emergency Contact_____ Phone_____

Person responsible for this account_____

Do you have dental insurance? ☐ Yes ☐ No

Name of Insurance Carrier_____

Policy Number_____ Certificate Number_____

Who may we thank for your referral?_____

Dental History

When was your last dental visit?_____

When did you last have dental x-rays?_____

How often do you brush your teeth?_____

How often do you floss your teeth?_____

YES NO

Have you been seeing a dentist regularly? YES / NO

Do any of your teeth ache? YES / NO

Have you ever been advised to take antibiotics before dental appointments? YES / NO

Do your gums bleed when you brush? YES / NO

Have you ever been in a vehicle accident or experienced any blows to your jaw? YES / NO

Have you ever had any implant surgery in your jaws or jaw joints? YES / NO

Please list anything else not mentioned above regarding your past dental history._____

TMJ & Sleep Therapy Centre of Auckland

Medical History

Name of Physician_____ Phone_____ OHIP#_____

Are you being treated for any medical condition at present or within the last year? YES / NO

When was your last medical check-up? _____

Has there been any change in your general health in the past year? YES / NO

Please list all medications you are currently taking, both prescription and non-prescription.

_____

_____

Do you have any allergies? YES / NO (please list)_____

Have you ever had an adverse reaction to any medicines or injections? YES / NO

Do you have any heart or blood pressure problems? YES / NO

Do you have a heart murmur or mitral valve prolapse? YES / NO

Have you ever had rheumatic fever? YES / NO

Do you have or have you ever had jaundice, hepatitis, or liver disease? YES / NO

Have you ever been told that you should not give blood? YES / NO

Do you have any conditions that could affect your immune system (e.g. AIDS, HIV, leukemia)? YES / NO

Do you have a tendency to bruise easily or bleed for a prolonged period of time? YES / NO

Have you ever been hospitalized for any serious illnesses or operations? YES / NO

Have you ever had any radiation therapy about the head or neck? YES / NO

Do you have or have you ever had any of the following? (Please tick off only those that apply.)

☐ epilepsy ☐ diabetes ☐ bronchitis ☐ asthma ☐ tuberculosis ☐ emphysema

☐ heart attack ☐ stroke ☐ stomach ulcers ☐ arthritis ☐ prosthetic joint(s) ☐ angina

☐ kidney disease ☐ cancer ☐ drug/alcohol addiction ☐ pacemaker ☐ psychiatric disorder artificial valve

Are there any other conditions or diseases not listed above which we should be made aware of?

_____

Do you smoke or chew tobacco? YES / NO If yes, how much and for how long?_____

For women only: are you pregnant? YES / NO If yes, expected delivery date_____

Notes/follow-up information_____

_____

To the best of my knowledge, the above information is correct.

_____ _____

(signature of patient) (date) (reviewed by treating dentist) (date)

TF Dental - Office Policies

After consenting to treatment, I authorize the dentists TMJ and Sleep Therapy Centre to perform any procedures, including the use of radiographs and drugs, which are necessary for my oral health. I assume responsibility for the fees associated with those procedures. Our office policy is such that services are paid for as they are rendered at each visit. If you have dental insurance, your carrier will remit payment directly to you. However, under special circumstances arrangements for payment can be made by consulting with the treating dentist and business associates before the treatment is performed. Please note that your appointment time is especially reserved for you. If you cannot keep the appointment we require 48 hours notice. If we do not receive sufficient notice you will be charged for the lost time. We appreciate that you respect our time as much as we value yours.

I have read and understand the above, and agree to comply with the stated office policies.

_____ _____

(print name of patient) (signature of patient) (signature of witness) (date)