NEW PATIENT INTAKE FORM

Patient Name: _____ _____
First Last

Title: Mr/Ms/Mrs/etc ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Occupation: _____ Employer: _____

Birth Date: _____ Email Address: _____
DD MM Year

Phone: _____ _____ _____ _____ Best time to call: _____
Home Work Ext Mobile

Address: _____

_____ _____ _____
City Province Postal Code

What is the best way for us to reach you? _____ _____
Phone Email

Favourite type of music: _____

Provincial Health Card Information (Province/Number): _____

Emergency Contact Name: _____ Emergency Contact Number: _____

How did you hear about us?

☐ Google ☐ Signage ☐ Social Media ☐ Website ☐ Friend/Family/Word of Mouth

Who referred you? ☐ Other (We'd love to learn how you heard about us!): _____

MEDICAL HISTORY

How would you describe your general health? ◯ Good ◯ Fair ◯ Poor

Family Physician Name: _____ Family Physician Contact Information: _____

Preferred Pharmacy (if applicable): _____

PLEASE CHECK OFF ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU.

☐ Allergy. If yes, please list:

☐ Acid Reflux	☐ Arthritis	☐ Asthma	☐ Autoimmune Disorder
☐ Pacemaker	☐ Blood disorder, such as anemia	☐ Cancer/Tumors	☐ Diabetes
☐ Heart condition	☐ High/Low Blood Pressure	☐ Chest Pains	☐ HIV/AIDS
☐ Hives or skin rash	☐ Fainting spells, seizures, or epilepsy	☐ Kidney disease	☐ Lung Disease
☐ Mental health challenges	☐ Osteoporosis	☐ Rheumatic Fever	☐ Sinus Trouble
☐ Shortness of breath	☐ Stroke	☐ Stomach ulcers	☐ Thyroid Disease
☐ Ulcers	☐ Cardiovascular disease (Heart attack, coronary occlusion, coronary insufficiency, arteriosclerosis)		
☐ Hepatitis A/B/C, jaundice, or liver disease	☐ Heart valve replacement or pathology		

Are you pregnant? ◯ Yes ◯ No

If so, expected delivery date: _____

Are you breastfeeding? ◯ Yes ◯ No

Are you taking contraceptives or hormones? _____

QUESTIONS

What medications are you currently taking (prescription or non-prescription)?

Are you under the care of a physician for a specific chronic condition? If so, please specify condition:

Date of last check-up: _____
DD MM Year

Have you had any major surgeries in the last two years? ◯ Yes ◯ No

Does your mouth frequently become dry? ◯ Yes ◯ No

Have you experienced numbness or tingling in any part of your body? ◯ Yes ◯ No

Do you bruise easily? ◯ Yes ◯ No

Do you smoke, chew tobacco products, or vape? If yes, how often? For how long?

Do you vape? ◯ Yes ◯ No

Do you participate in social drug use? ◯ Yes ◯ No

Do you wear contact lenses? ◯ Yes ◯ No

Do you have a prosthetic or artificial joint? If so, please list:

Do your ankles swell?

◯ Yes ◯ No

Do you suffer from frequent headaches or spells of dizziness? ◯ Yes ◯ No

Do you have any other health conditions we should be aware of that are not listed above?

DENTAL HISTORY

Name of Previous Dentist: _____ Previous Dentist Contact Information: _____

Have you had any abnormal bleeding associated with previous dental work (extractions, surgery, or trauma)? ◯ Yes ◯ No

When were your last dental x-rays taken?

Would you like your previous dental x-rays transferred to Norwood Dental from your previous dental office?
(If yes, we will have a separate form for you to fill out to request your files be transferred.There is no cost to you to transfer files).

◯ Yes ◯ No

How would you describe yourself as a dental patient ?

◯ Calm ◯ Somewhat Anxious ◯ Very Anxious

How would your rate your smile from 1 to 10, with 10 being highest?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Have you noticed any of the following:

☐ Bleeding/swelling gums ☐ Gum Ache ☐ Jaw Pain/Noise

☐ Loose/Drifting Teeth ☐ Receding Gums ☐ Tooth Sensitivity

Is there anything else we should know about before treating you?

PATIENT AUTHORIZATION

I hereby certify that I have provided an accurate and complete medical-dental history, and have not knowingly omitted any information. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the dentist to contact my medical doctor for further information on my health if necessary. In addition, I consent to the collection, use, retention, and disclosure of my personal information as is required for my, and that of my dependents, dental care.

Name : _____ Signature : _____ Date : _____

Relationship to Patient: Self/Guardian/Parent (Please circle)

At Norwood Dental Centre, each patient is important and treated with care, comfort, and kindness. Our goal is to put you at ease and provide quality oral care consistent with your needs and budget.

Thank you for being our patient!