JOHNSON DENTAL

Patient Information

Registration Information

Name_______________________________________ Date of Birth____

Home phone: __________________ Work phone: __________________ Cell:_________________________

Address_________________________City____________________________________Postal Code_____________

Email address____

Employer____Occupation__________________________________

Emergency Contact____Number______________________

Parent/Guardian (if applicable) ____

Who may we thank for referring you to our office? ____

Communication

As my dental care provider, you may do the following with my permission:

Contact me at home	Yes or No
Contact me via cell phone	Yes or No
Contact me via text message	Yes or No
Contact me at work	Yes or No
Contact me via e-mail	Yes or No
Leave messages on my home voicemail/answering machine	Yes or No
Leave messages on my cell phone voicemail	Yes or No
Leave messages on my work voicemail/answering machine	Yes or No

What is your preferred method of communication? ____

Release Information

May we discuss your healthcare with:

Health care Providers Yes or NO
Insurance Companies Yes or NO
Other__________________________

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Office Policies

Appointments:

Once you have made an appointment, that time is reserved especially for you. If you are unable to keep this reservation, please let us know at least 24 hours in advance. In the event of a missed appointment or a short notice cancellation, a minimum **$50.00 fee** will be assessed depending on the length of appointment cancelled.

Financial:

The insurance plan which you have is a contract between you and your insurance company. You will therefore be financially responsible for all unpaid balanced not paid by your insurance company.

Payment is due in full at the time of treatment unless prior arrangement has been approved.

Signature of patient/parent/guardian: __________________________________ Date: _______________

Drs. Robert and Melanie Johnson Inc.

670 11th Street N.E.   Salmon Arm, B.C, V1E 2Z1   Tel:250-832-2264   johnsondentalsa@gmail.com

JOHNSON DENTAL

Health History Questionnaire

Physician's name___________________________ Date of last doctor visit_________________________

What is your estimate of your general health? ○ Excellent ○ Good ○ Fair ○ Poor

Have you ever been recommended to take antibiotics prior to dental treatment or surgery? Yes or No

Please list any allergies you have (drug allergies, latex, seasonal etc.) ______________________________

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Please check all that apply to your current and past medical history:

- ○ Arthritis
- ○ Artificial joints
- ○ Asthma
- ○ Autoimmune disease
- ○ Back/neck pain
- ○ Blood disorder
- ○ Breathing problems
- ○ Cancer
- ○ Cardiac Stent
- ○ Chemotherapy
- ○ Clotting/bleeding problems
- ○ Cold sores
- ○ Currently pregnant
- ○ Depression
- ○ Diabetes
- ○ Drug use
- ○ Ear congestion
- ○ Hospitalization for illness or injury
- ○ Facial pain
- ○ Fainting
- ○ Fibromyalgia
- ○ Gastrointestinal issues
- ○ Growth or Tumor
- ○ Heart attack
- ○ Heart disease
- ○ Hepatitis A/B/C
- ○ High blood pressure
- ○ High cholesterol
- ○ Hormone deficiency
- ○ Insomnia
- ○ Jaundice
- ○ Kidney problems
- ○ Liver problems
- ○ Low blood pressure
- ○ Mental/Nervous disorders
- ○ Infective endocarditis of the heart
- ○ Migraines/Headaches
- ○ Pacemaker
- ○ Poor sleep quality
- ○ Prostate disorder
- ○ Radiation therapy
- ○ Rheumatic or scarlet fever
- ○ Sinus issues
- ○ Sleep apnea
- ○ Snoring
- ○ STI/STD/HPV
- ○ Stroke
- ○ Surgery
- ○ Thyroid problems
- ○ Tinnitus (ringing in ears)
- ○ Tuberculosis
- ○ Ulcers
- ○ Vertigo
- ○ Often feel exhausted or fatigued

○ Do you consume alcohol daily or weekly? Yes or No ○ Do you use tobacco products? Yes or No

Is there anything else you would like us to know about your health? ___________________________

____

Please list all medications, supplements, and vitamins you currently take.

Drug	**Purpose**	**Drug**	**Purpose**
______________	_________________________	______________	_________________________
______________	_________________________	______________	_________________________
______________	_________________________	______________	_________________________

Please advice 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__________________

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Dental History Questionnaire

Do you have an immediate dental concern? ____

Previous dentist________________________ Date of last dental treatment____________________________

Date of last dental cleaning________________ Date of last dental X-rays________________________________

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

How often do you: Brush__________________ Floss___________________

How would you rate the condition of your mouth: excellent good fair poor

Personal History

On a scale of 1-10 (1=nervous, 10=comfortable) please rate your comfort level with the dentist______________

Have you ever had trouble getting numb or had a reaction to local anesthetic?.....................................Yes or No

Have you ever had extracted teeth or a root canal?...Yes or No

Have you ever had braces or orthodontic treatment or had your bite adjusted?......................................Yes or No

Gums and Bone

Do your gums bleed or are they painful when brushing or flossing?..Yes or No

Have you ever been treated for gum disease or ever been told you've lost bone around your teeth?.......Yes or No

Have you ever noticed an unpleasant taste or odour in your mouth?...Yes or No

Is there anyone if your family with a history of periodontal or gum disease?..Yes or No

Are you aware of having any areas of gum recession?...Yes or No

Have you had any teeth come loosen their own (without an injury)?...Yes or No

Tooth Structure and Prevention

Have you had any cavities in the last 3 years?...Yes or No

Do you experience a dry mouth?...Yes or No

Do you mostly breath through your mouth (versus your nose)?...Yes or No

Do you feel any holes, pits or ledges on your teeth?...Yes or No

Do you get food caught between any of your teeth?...Yes or No

Does floss catch or tear between any of your teeth?...Yes or No

Bite and Jaw Joint

Do you experience any pain with your jaw joint or facial muscles?..Yes or No

Does your jaw make any noises while chewing, eating or opening?...Yes or No

Do you avoid or have difficultly chewing hard/dry or tough foods (i.e. carrots, nuts, bagels)?..................Yes or No

Are you aware of doing any grinding of clenching?...Yes or No

Have you ever worn a bite appliance or night guard?..Yes or No

Do you have more than one bite or need to shift your jaw to make your teeth fit together?....................Yes or No

Have your teeth changed in the last five years becoming shorter, thinner or more worn?........................Yes or No

Are any of your teeth sensitive to hot, cold, biting, sweet or sensitive to brushing?.................................Yes or No

Smile Characteristics

Is there anything about your smile that you wish were different?..Yes or No

Is there anything about the appearance of your teeth that you would like to change?..............................Yes or No

Have you ever whitened (bleached) your teeth?...Yes or No

Have you felt uncomfortable or self-conscious about the appearance of your teeth?................................Yes or No

Have you ever been disappointed with previous dental work?..Yes or No

Patient Signature____Date__________

Dentist Signature____Date__________

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