1092, 102nd ST
North Battleford, SK, S9A 1E6
PH: (306)446-8898 FAX: (306)446-0868
twincitydentalclinic@gmail.com

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information

First name - Patient

Middle name
-

Last name - Patient

Patient date of birth
-

Gender

Email address
-

Contact Information

Home #

Work #
-

Mobile #
-

Patient mailing address

Patient billing address

Emergency Information

Emergency contact
-

Emergency #
-

Family doctor
-

☐ Has the main contact for the family, (usually a parent or guardian) changed since your last visit?
-

Family doctor #
-

☐ Has the main person responsible for payments for the family, (usually a parent or guardian) changed since your last visit?
-

Other Information

Social insurance number

-

Occupation

-

- [ ] Has your insurance information changed since your last visit?

-

Dental Information

- [ ] Do your gums bleed when you brush or floss?
- [ ] Are you currently experiencing dental pain or discomfort?
- [ ] Are your teeth sensitive to cold, hot, sweets, or pressure?
- [ ] Do you have earaches or neck pains?
- [ ] Does food or floss catch between your teeth?
- [ ] Do you have any clicking, popping or discomfort in your jaw?
- [ ] Have you had any periodontal (gum) treatment?
- [ ] Do you grind your teeth?
- [ ] Have you ever had orthodontic (braces) treatment?
- [ ] Do you have any sores or ulcers in your mouth?
- [ ] Have you had any problems associated with previous dental treatment?
- [ ] Do you wear partial dentures?
- [ ] Is your home water supply fluoridated?
- [ ] Do you wear full dentures?
- [ ] Do you drink bottled or filtered water?
- [ ] Have you ever had a serious injury to your head, neck or mouth?

-

Medical Information

Allergies

- [ ] Acetaminophen/Tylenol®
- [ ] Acrylic
- [ ] Animals
- [ ] Aspirin
- [ ] Codeine
- [ ] Demerol
- [ ] Erythromycin
- [ ] Fluoride
- [ ] Food
- [ ] Hay fever/seasonal
- [ ] Ibuprofen/Motrin®/Advil®
- [ ] Iodine
- [ ] Latex
- [ ] Local anesthetic
- [ ] Metals
- [ ] Morphine
- [ ] Penicillin
- [ ] Sulfa
- [ ] Tetracycline
- [ ] Other

-

Reactions

-

Conditions

- [ ] Abnormal/excessive bleeding
- [ ] AIDS or HIV infection
- [ ] Alzheimer's/dementia
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune disease
- [ ] Back problems
- [ ] Blood disease
- [ ] Blood transfusion
- [ ] Breathing problems/ respiratory disease
- [ ] Bronchitis
- [ ] Cancer/chemotherapy/ radiation treatment
- [ ] Cardiovascular disease
- [ ] Chest pain upon exertion
- [ ] Chronic pain
- [ ] Congestive heart failure
- [ ] Damaged heart valves
- [ ] Diabetes
- [ ] Eating disorder
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Fainting spells or seizures
- [ ] Frequent headaches
- [ ] Gastrointestinal disease
- [ ] G.E. Reflux/persistent heartburn
- [ ] Glaucoma
- [ ] Gout
- [ ] Hearing difficulties
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Heart rhythm disorder
- [ ] Hemophilia
- [ ] Hepatitis, jaundice or liver disease
- [ ] High blood pressure
- [ ] Kidney problems
- [ ] Low blood pressure
- [ ] Low pain tolerance
- [ ] Malnutrition
- [ ] Mitral valve prolapse
- [ ] Neurological disorders
- [ ] Night sweats
- [ ] Osteoporosis/Paget's disease
- [ ] Other congenital heart defects
- [ ] Pacemaker
- [ ] Persistent swollen glands in neck
- [ ] Psychiatric care
- [ ] Recurrent Infections
- [ ] Rheumatic fever
- [ ] Rheumatic heart disease
- [ ] Rheumatoid arthritis
- [ ] Severe headaches/migraines
- [ ] Severe or rapid weight loss
- [ ] Sexually transmitted infection (STI)
- [ ] Sinus trouble
- [ ] Stroke
- [ ] Systemic lupus erythematosus
- [ ] Thyroid problems
- [ ] TMJ Disorder
- [ ] Tuberculosis
- [ ] Tumors or growths
- [ ] Ulcers
- [ ] Other

-

Jun 09, 2024 Health History

Details

-

Please indicate if you have or any of the following diseases or problems.

Preferred pharmacy

-

Pharmacy #

-

Date of last physical exam

-

☐ Do you have severe issues with coughing?

-

☐ Have you ever reacted adversely to any medications or injections?

☐ Do you drink alcoholic beverages?

-

☐ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

-

☐ Has there been any change to your general health within the past year?

-

☐ Do you use tobacco (smoking, snuff, chew, bidis)?

-

☐ Have you had a serious illness, operation or been hospitalized in the past 5 years?

-

☐ Are you wearing a nicotine patch?

☐ Are you taking any prescription or over-the-counter medicines?

-

☐ Do you have sleep apnea?

☐ Are you pregnant?

-

☐ Are you taking birth control or hormone replacement?

☐ Are you nursing?

Please list any surgical procedures you have undergone and when they occurred.

-

☐ Have you ever taken FosaMax®, Boniva®, Actonel® or other medications containing bisphosphonates?

☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

-

Jun 09, 2024 Health History

Physician's phone number

-

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Patient Agreement

I acknowledge that the information provided in this form is accurate and truthful. A complete health history is essential for effective dental treatment. The information shared will be used by the doctor and patient to facilitate any necessary discussions regarding my health prior to or during appointments. By signing below, I understand and agree not to hold the dentist, the dental practice, or any staff member liable for any actions or lack thereof resulting from errors or omissions made during the completion of this form.

I also understand that Twin City Dental Clinic acts as a third-party associate for insurance purposes and offers direct billing as a courtesy. In cases of errors, discrepancies, or unpaid claims, it is my responsibility to settle accounts directly with the dental practice and follow up with my insurance provider.

Patient Name: _____

Signature: _____

Date: _____