

# Welcome to Tuscany Dental Centre

The benefits of a happy, beautiful smile are immeasurable! Our goal is to help you reach and maintain your oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

☐ Male ☐ Female

☐ Dr ☐ Mr ☐ Mrs ☐ Ms

Name: First: \_\_\_\_\_

Middle: \_\_\_\_\_

Last: \_\_\_\_\_

I Prefer to be called: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Date of Birth: (Month/Day/Year): \_\_\_\_\_

Home Tel: \_\_\_\_\_

Work Tel: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Email: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

## Insurance:

1st Insurance Company: \_\_\_\_\_ 2nd Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Group / Policy#: \_\_\_\_\_ Group / Policy#: \_\_\_\_\_

I.D#: \_\_\_\_\_ I.D#: \_\_\_\_\_

DOB (m/d/y): \_\_\_\_\_ DOB (m/d/y): \_\_\_\_\_

## Privacy Information

How we collect, use and disclose your information:

When you do business with us you share personal information so that we may provide you with the treatment, services, and products that best meet your needs. We assure your consent for our office to use this information in an appropriate manner – to evaluate and process insurance claims and to detect and prevent fraud. We do not sell client information. All employees, associated advisors and insurance companies who are granted access to client records understand the need to keep this information protected and confidential. You may withdraw your consent at any time – by providing us with 30 days notice by contacting our office at (403)239-0010. Please be aware that withdrawing your consent may prevent us from providing you with requested treatment or services. Your appointment time is reserved especially for you. If you are unable to keep this time we require 48 hours notice to reschedule. I hereby assign my benefits, payable from claims submitted electronically to Dr Cam Brauer / Dr Scott Townsend and authorize payment directly to him. This authorization shall continue in effect until the undersigned revokes the same.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

Name of Physician / and their speciality \_\_\_\_\_

Most recent physical examination \_\_\_\_\_

Purpose \_\_\_\_\_

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

## Do You Have or Have You Ever Had:

1. hospitalization for illness or injury \_\_\_\_\_ ☐ Yes ☐ No

2. an allergic reaction to \_\_\_\_\_

- |   |  |
|---|--|
| <input type="radio"/> aspirin, ibuprofen, acetaminophen | <input type="radio"/> penicillin                     |
| <input type="radio"/> erythromycin                      | <input type="radio"/> tetracycline                   |
| <input type="radio"/> codeine                           | <input type="radio"/> local anesthetic               |
| <input type="radio"/> fluoride                          | <input type="radio"/> metals (gold, stainless steel) |
| <input type="radio"/> latex                             | <input type="radio"/> any other medications          |

3. diarrhea, persistent cough or undiagnosed skin rash \_\_\_\_\_ ☐ Yes ☐ No

4. heart problems \_\_\_\_\_ ☐ Yes ☐ No

5. heart murmur \_\_\_\_\_ ☐ Yes ☐ No

6. rheumatic fever \_\_\_\_\_ ☐ Yes ☐ No

7. scarlet fever \_\_\_\_\_ ☐ Yes ☐ No

8. high blood pressure \_\_\_\_\_ ☐ Yes ☐ No

9. low blood pressure \_\_\_\_\_ ☐ Yes ☐ No

10. a stroke \_\_\_\_\_ ☐ Yes ☐ No

11. artificial prosthesis (ie heart valve or joints) \_\_\_\_\_ ☐ Yes ☐ No

12. anemia or other blood disorder \_\_\_\_\_ ☐ Yes ☐ No

13. prolonged bleeding with a slight cut \_\_\_\_\_ ☐ Yes ☐ No

14. emphysema \_\_\_\_\_ ☐ Yes ☐ No

15. tuberculosis \_\_\_\_\_ ☐ Yes ☐ No

16. asthma \_\_\_\_\_ ☐ Yes ☐ No

17. breathing or sleep problems (ie snoring, sinus) \_\_\_\_\_ ☐ Yes ☐ No

18. kidney disease \_\_\_\_\_ ☐ Yes ☐ No

19. liver disease \_\_\_\_\_ ☐ Yes ☐ No

20. jaundice \_\_\_\_\_ ☐ Yes ☐ No

21. thyroid or parathyroid disease \_\_\_\_\_ ☐ Yes ☐ No

22. hormone deficiency \_\_\_\_\_ ☐ Yes ☐ No

23. high cholesterol \_\_\_\_\_ ☐ Yes ☐ No

24. diabetes \_\_\_\_\_ ☐ Yes ☐ No

25. stomach or duodenal ulcer \_\_\_\_\_ ☐ Yes ☐ No

26. digestive disorders (ie gastric reflux or celiac) \_\_\_\_\_ ☐ Yes ☐ No

27. osteoporosis / osteopenia (ie taking bisphosphonates) \_\_\_\_\_ ☐ Yes ☐ No

28. arthritis \_\_\_\_\_ ☐ Yes ☐ No

29. glaucoma \_\_\_\_\_ ☐ Yes ☐ No

30. contact lenses \_\_\_\_\_ ☐ Yes ☐ No

31. head or neck injuries \_\_\_\_\_ ☐ Yes ☐ No

32. epilepsy, convulsions (seizures), fainting \_\_\_\_\_ ☐ Yes ☐ No

33. Neurological problems \_\_\_\_\_ ☐ Yes ☐ No

34. viral infections and/or cold sores \_\_\_\_\_ ☐ Yes ☐ No

35. any lumps or swelling in the mouth \_\_\_\_\_ ☐ Yes ☐ No

36. hives, skin rash, hay fever \_\_\_\_\_ ☐ Yes ☐ No

37. venereal disease \_\_\_\_\_ ☐ Yes ☐ No

38. hepatitis (type \_\_\_\_ ) \_\_\_\_\_ ☐ Yes ☐ No

39. HIV / AIDS \_\_\_\_\_ ☐ Yes ☐ No

40. tumor, abnormal growth \_\_\_\_\_ ☐ Yes ☐ No

41. radiation therapy \_\_\_\_\_ ☐ Yes ☐ No

42. chemotherapy \_\_\_\_\_ ☐ Yes ☐ No

43. psychiatric treatment \_\_\_\_\_ ☐ Yes ☐ No

44. antidepressant medication \_\_\_\_\_ ☐ Yes ☐ No

45. alcohol / drug dependency \_\_\_\_\_ ☐ Yes ☐ No

## ARE YOU:

46. presently being treated for any other illness \_\_\_\_\_ ☐ Yes ☐ No

47. aware of a change in your general health \_\_\_\_\_ ☐ Yes ☐ No

48. taking medication for weight management \_\_\_\_\_ ☐ Yes ☐ No

49. often exhausted or fatigued \_\_\_\_\_ ☐ Yes ☐ No

50. subject to frequent headaches \_\_\_\_\_ ☐ Yes ☐ No

51. a smoker or smoked previously \_\_\_\_\_ ☐ Yes ☐ No

52. FEMALE – taking birth control pills \_\_\_\_\_ ☐ Yes ☐ No

53. FEMALE – pregnant \_\_\_\_\_ ☐ Yes ☐ No

54. MALE – prostate disorders \_\_\_\_\_ ☐ Yes ☐ No

# DENTAL HISTORY

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: ☐ 3mths ☐ 4mths ☐ 6mths ☐ 12mths ☐ Not recently

What is your immediate concern? \_\_\_\_\_

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

## PERSONAL HISTORY



1. Are you fearful of dental treatment? Scale of 1 (least) to 10 (most) (\_\_\_\_\_) ☐ ☐
2. Have you had an unfavorable dental experience? ☐ ☐
3. Have you ever had complications from past dental treatment? ☐ ☐
4. Have you ever had trouble getting numb or reactions to local anesthetic? ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ☐ ☐
6. Have you had any teeth removed? ☐ ☐

## GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth ☐ ☐
9. Have you ever noticed a unpleasant taste or odor in your mouth? ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ☐ ☐
11. Have you ever experienced gum recession? ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ☐ ☐
13. Have you experienced a burning sensation in your mouth? ☐ ☐

## TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? ☐ ☐
15. Does the amount of saliva in your mouth seem to little or do you have difficulty swallowing any food? ☐ ☐
16. Do you feel or notice any holes (ie pitting, craters) on the biting surface of your teeth? ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth? ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ☐ ☐
19. Have you ever broken teeth, chipped teeth or had a toothache or cracked filling? ☐ ☐
20. Do you frequently get food caught between any teeth? ☐ ☐

## BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? ☐ ☐
28. Do you place your tongue between your teeth or rest your teeth against your tongue? ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or any awareness of your teeth? ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ☐ ☐

## SMILE CHARACTERISTICS



33. Is there anything about the appearance of your teeth that you would like to change? ☐ ☐
34. Have you ever whitened (bleached) your teeth? ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ☐ ☐

Doctors's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_