Tooth Connection Dental
where smiles come alive

MEDICAL HISTORY

PERSONAL INFORMATION

○ Mr. ○ Mrs. ○ Ms. ○ Miss. ○ Dr. ○ MALE ○ FEMALE ○ NON-BINARY

NAME: _____ DOB: _____
LAST FIRST MIDDLE MM/DD/YYYY

PREFERRED NAME: _____ NAME OF GUARDIAN (IF APPLICABLE): _____

ADDRESS: _____ APT/UNIT: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____ EXT: _____

EMAIL: _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT: _____ PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT US? ○ SOCIAL MEDIA ○ GOOGLE ○ PATIENT OF THE OFFICE: _____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT AND PAYMENT: _____

ADDRESS: _____ PHONE NUMBER: _____

PRIMARY BENEFIT INFORMATION

POLICY HOLDER: _____ DOB: _____
NAME AS IT APPEARS ON BENEFIT CARD MM/DD/YYYY

EMPLOYER: _____ DENTAL INSURANCE COMPANY: _____

POLICY #: _____ CERTIFICATE #: _____

SECONDARY BENEFIT INFORMATION

POLICY HOLDER: _____ DOB: _____
NAME AS IT APPEARS ON BENEFIT CARD MM/DD/YYYY

EMPLOYER: _____ DENTAL INSURANCE COMPANY: _____

POLICY #: _____ CERTIFICATE #: _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT: ○ Examination ○ Emergency: _____ ○ Other: _____

IS THERE A DENTAL PROBLEM YOU'D LIKE TREATED IMMEDIATELY? _____

DATE OF LAST DENTAL VISIT: _____ LAST CLEANING: _____ LAST X-RAYS: _____
MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY

DO YOU HAVE ANXIETY WITH DENTAL TREATMENT? ○ Yes ○ No

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ HOW OFTEN DO YOU FLOSS YOUR TEETH? _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

- ☐ Orthodontics
- ☐ Oral/Gum Surgery
- ☐ Injury or Surgery to Face/Jaw
- ☐ Jaw Pain or Clicking
- ☐ Dentures
- ☐ Clenching
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Headaches/Migraines
- ☐ Grinding
- ☐ Oral Sores or Growths
- ☐ Sensitivity to Hot or Cold

HAVE YOU EVER BEEN ADVISED TO TAKE ANTIBOTICS BEFORE A DENTAL APPOINTMENT? ○ YES ○ NO

IF YES, PLEASE EXPLAIN: _____

ARE YOU COMPLETELY HAPPY WITH THE SHAPE, COLOUR AND POSITION OF YOUR TEETH? ○ YES ○ NO

IF NO, PLEASE EXPLAIN: _____

ON A SCALE OF 1 TO 10 (10 BEING THE HIGHEST), PLEASE RATE HOW IMPORTANT YOUR ORAL HEALTH IS TO YOU: _____

MEDICAL HISTORY

DO YOU HAVE A PRIMARY PHYSICIAN? ○ YES ○ NO

PHYSICIAN NAME: _____ LAST EXAM DATE: _____
MM/DD/YYYY

WERE ANY PROBLEMS IDENTIFIED? ○ YES ○ NO

IF YES, PLEASE EXPLAIN: _____

DO YOU SMOKE / CHEW TOBACCO OR VAPE? ○ YES ○ NO - IF YES, HOW MANY PER DAY? _____

DO YOU DRINK ALCOHOL? ○ YES ○ NO – IF YES, HOW MANY DRINKS PER WEEK? _____

DO YOU USE CANNABIS OR OTHER RECREATIONAL DRUGS? ○ YES ○ NO – IF YES, HOW OFTEN? _____

ARE YOU PREGNANT OR SUSPECT YOU MAY BE? ○ YES ○ NO – IF YES, WHEN IS YOUR DUE DATE? _____

DOES YOUR FAMILY HAVE HISTORY OF CANCER, HEART DISEASE OR DIABETES? ○ YES ○ NO

IF YES, WHAT TYPE: _____

HAVE YOU EXPERIENCED COMPLICATIONS FOLLOWING A MEDICAL OR DENTAL PROCEDURE? ○ YES ○ NO

DO YOU TAKE MEDICATION FOR OSTEOPOROSIS? ○ YES ○ NO – IF YES, WHAT TYPE? _____

HAVE YOU EVER HAD RADIATION TREATMENT TO THE HEAD OR NECK REGION? ○ YES ○ NO

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer: _____
- ☐ Chemo/Radiation Therapy
- ☐ COPD
- ☐ Diabetes Type I / Type II
- ☐ Drug/Alcohol Dependency
- ☐ Easy Bleeding or Bruising
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting/Dizzy Spells
- ☐ Gastrointestinal Disorders
- ☐ Glaucoma
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ HIV+/AIDS
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Lupus/Autoimmune
- ☐ Mental Health Conditions
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Scarlet Fever
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vision Impairment
- ☐ Other: _____

PLEASE LIST ANY ALLERGIES OR SENSITIVITIES: (INCLUDING BUT NOT LIMITED TO FOOD, LATEX, METALS, ANTIBIOTICS)

_____ _____

_____ _____

PLEASE LIST ANY MEDICATIONS, DOSAGES AND CONDITIONS TAKEN FOR (INCLUDE SUPPLEMENTS):

_____ _____

_____ _____

ANYTHING ELSE ABOUT YOUR HEALTH THAT WE SHOULD KNOW:

_____

_____

CONSENT FORMS

CONSENT TO MEDICAL HISTORY AND CONSULTATION

I hereby state that the above information is, to the best of my knowledge, accurate and complete. If I ever have any change in My health, or if my medicines change, I will inform the doctor without fail, if deemed advisable. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I grant permission for my physician, other healthcare providers and my insurance involved in my treatment to be contacted by Dr. Rachel Kitsopanidi and staff for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

Patient/Guardian Signature: _____ Print Name: _____ Date: _____

CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I hereby acknowledge that a copy of this office's Policy of Collection, Use and Disclosure of Personal Information has been made readily accessible to me. I have been given the opportunity to review this notice and ask any questions I may have. My signature below signifies that I understand how your office will use my personal information, and the steps your office is taking to protect my information. I agree that Dr. Rachel Kitsopanidi and staff can collect, use and disclose personal information about me as set out in the information about the office's privacy policies.

Patient/Guardian Signature: _____ Print Name: _____ Date: _____

APPOINTMENT POLICY

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us ***2 business days (48 hours) notice*** *if they cannot keep an appointment. Appointment changes with less than 48 hours' notice are subject to* ***a $50.00 service fee****.*

It is my responsibility to confirm appointments, and I understand that if I do not confirm my appointment, there is a risk of the appointment being rescheduled. Patients that do not show up for their appointments may not be booked again.

Patient/Guardian Signature: _____ Print Name: _____ Date: _____

CONSENT TO THE MEDIA RELEASE OF PATIENT PHOTOS

I hereby authorize Dr. Rachel Kitsopanidi or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that my photos may be used in social media posts (Instagram and Facebook), company website gallery, and in educational publications/lectures/convention for case presentations. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient/Guardian Signature: _____ Print Name: _____ Date: _____

Dentist Signature: _____ Date: _____

TOOTH CONNECTION DENTAL
7777 WESTON RD UNIT 218 WOODBRIDGE ON L4L 0G9 (905) 605-9001