DR GRANT MOLDENHAUER AND ASSOCIATES NEW PATIENT INFORMATION SHEET

MEDICAL ALERT: _____

The following information is required to enable us to provide you with the best professional care. All information is strictly private, and is protected by doctor-patient confidentiality. Dr. Moldenhauer, Dr. Piercy or one of our staff will review the questions and explain any that you do not understand. Please fill in the entire form. Thank you.

PATIENT LAST NAME	MR MRS MS MISS DR GIVEN NAMES	MARITAL STATUS

ADDRESS	TOWN or CITY	POSTAL CODE

DATE OF BIRTH (MM/DD/YYYY)	HOME PHONE NUMBER	BUSINESS PHONE NUMBER	CELL NUMBER

ALBERTA HEALTHCARE #

EMAIL ADDRESS	EMERGENCY CONTACT & #	RELATIONSHIP

YOUR OCCUPATION	EMPLOYER

NAME OF PRIMARY INSURANCE COMPANY	POLICY / GROUP	DIVISION / SECTION	CERTIFICATE / ID

HOW DID YOU HEAR ABOUT OUR OFFICE?

IF YOU HAVE SECONDARY INSURANCE PLEASE PROVIDE INFORMATION TO ASSIST US WITH YOUR CLAIM

NAME OF POLICYHOLDER FOR SECONARY INSURANCE	OCCUPATION	EMPLOYER

DATE OF BIRTH (MM/DD/YYYY)	HOME PHONE NUMBER (IF DIFFERENT TO ABOVE)	BUSINESS PHONE NUMBER	CELL NUMBER

NAME OF SECONDARY INSURANCE COMPANY	POLICY / GROUP	DIVISION / SECTION	CERTIFICATE / ID

DENTAL HISTORY

	PLEASE CIRCLE		
1) Are you having any pain or discomfort at this time?	Yes	No	Not Sure
2) Do you feel nervous about having dental treatment?	Yes	No	Not Sure
3) Have you ever had a bad experience in the dental office?	Yes	No	Not Sure
4) Do you have any sensitive teeth (e.g. to hot, cold pressure or sweet)?	Yes	No	Not Sure
5) Have you ever had a dental abscess or root canal treatment?	Yes	No	Not Sure
6) Have you ever had any orthodontic treatment?	Yes	No	Not Sure
7) Do you have any pain in your jaw, head or neck?	Yes	No	Not Sure
8) Do you ever experience any clicking, squishing or popping sound from your jaw when you open or close?	Yes	No	Not Sure
9) Do you suffer from any tension or migraine headaches?	Yes	No	Not Sure
10) Do you have problems opening or closing your mouth?	Yes	No	Not Sure
11) Are you aware of any clenching or squeezing of your teeth either at night or during the day?	Yes	No	Not Sure
12) Have you ever noticed any signs of gum disease (e.g. bleeding gums, receding gums, sore gums, and loose or drifting teeth?	Yes	No	Not Sure
13) Do you ever get any lumps, bumps, ulcers or cold sores in your mouth?	Yes	No	Not Sure
14) Do you have any lumps, bumps, ulcers or cold sores in your mouth now?	Yes	No	Not Sure
14) Do you like the appearance of your teeth and your smile?	Yes	No	Not Sure
15) Are you happy with the color of your teeth?	Yes	No	Not Sure
16) Are there any spaces, crooked teeth, chipped or worn teeth that you don't like?	Yes	No	Not Sure
17) Are you interested in whitening your teeth or changing your smile in any way?	Yes	No	Not Sure
16) What is the date of your most recent dental examination (MM/DD/YYYY)?			

MEDICAL HISTORY

	PLEASE CIRCLE		
1) When was your last Medical Checkup (MM/DD/YYYY)?			
2) Has there been any change in your general health or have you been treated for any medical condition in the last year? If yes, please explain.	Yes	No	Not Sure
3) Are you taking any medication, non-prescription drugs or herbal supplements of any kind? If yes please list or alternatively we can call your Pharmacist for a complete list.	Yes	No	Not Sure
4) Do you have any allergies? If you answered yes, please list using the categories below: A) Medications B) Latex or Rubber Products C) Other e.g. Hay fever, foods etc.	Yes	No	Not Sure
5) Have you ever had a peculiar or adverse reaction to any medication or injection e.g. Local Anesthetic, Codeine, Penicillin etc.? If yes, please explain.	Yes	No	Not Sure
6) Do you or have you ever had Asthma?	Yes	No	Not Sure
7) Do you or have you ever had any Heart or Blood Pressure problems?	Yes	No	Not Sure
8) Do you have or have you ever had a Heart Murmur, Mitral Valve Prolapse, Rheumatic Fever or Scarlet Fever?	Yes	No	Not Sure
9) Do you have a Prosthetic or Artificial Joint e.g. Heart Valves, Knee or Hip etc.?	Yes	No	Not Sure
10) Have you ever been advised by your doctor to take antibiotics before dental treatment? If so, why and what antibiotic did you take?	Yes	No	Not Sure
11) Do you have any conditions or therapies that could affect your immune system e.g. Leukemia, AIDS, HIV Infection, Radiotherapy, Chemotherapy?	Yes	No	Not Sure
12) Have you ever had Hepatitis (A, B or C), Jaundice or Liver Disease?	Yes	No	Not Sure
13) Do you have a Bleeding Problem or Bleeding Disorder e.g. Bruise Easily, Anemia, or Hemophilia etc.?	Yes	No	Not Sure
14) Have you ever been hospitalized for any illness or operations? If yes, please explain.	Yes	No	Not Sure

15) Do you have or have you ever had any of the following? Please circle.

Shortness of Breath	Lung Disease	Tuberculosis	Seizures (Epilepsy)	Arthritis	Snore	Fainting
Heart Attack	Prosthetic Heart Valve	Cold Sores	Thyroid Disease	Chest Pain or Angina	CPAP	Stroke
Stomach Ulcers	Pacemaker (Arrhythmia)	Diabetes	Steroid Therapy	Drug or Alcohol Dependency		Cancer
Diet Pill Therapy	Kidney Disease	Osteoporosis	Nervousness	Artificial Heart Valve		GERD

16) Are there any disease or medical problems that run in your family e.g. Diabetes, Cancer, Heart Disease etc.?	Yes	No	Not Sure
17) Are there any conditions or disease not listed above that you have or have had? If so, what?	Yes	No	Not Sure
18) Do you smoke or chew tobacco, cannabis or vape products and if so how much?	Yes	No	Not Sure
19) For women only: Are you on Oral Contraceptives?	Yes	No	Not Sure
Are you breast feeding or pregnant?	Yes	No	Not Sure
If pregnant, what is the expected delivery date?			

HEIGHT (FEET/INCHES)	WEIGHT (POUNDS)
FAMILY DOCTOR'S NAME	FAMILY DOCTOR'S PHONE NUMBER (IF KNOWN)
SPECIALIST'S NAME (IF YOU HAVE ONE)	SPECIALIST''S PHONE NUMBER (IF KNOWN)

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE

DATE: _____ PATIENT SIGNATURE: _____

DENTIST SIGNATURE: _____