CAPITAL PROSTHODONTICS
IMPLANT, RECONSTRUCTIVE + COSMETIC DENTISTRY

The following information is required to provide you with the highest standard of dental care. All information is strictly private and is protected by doctor-patient confidentiality. The doctor will review the questions and explain any that you do not understand. Please fill in the entire form.

PATIENT INFORMATION

Last Name: ◯ Male ◯ Female

First Name: Age:

Date of Birth: Occupation:

Parent/Guardian Name: Language Preference:

Home Address: Home Phone:

City: Cell Phone:

Province: Email:

Postal Code: Work Phone:

Provide email if you consent to receiving emails for appointment confirmations & general office communication. Your email will not be shared.

Marital Status: Name of Spouse or family member:

Person Financially Responsible for Account:

Do you have dental insurance? ◯ Yes ◯ No

If yes, please provide:

Name of insurance company:

Group/Policy/Plan Number:

Policy holder's name:

Policy holder's date of birth:

ID or certificate number:

Are you covered by any other dental insurance? ◯ Yes ◯ No

If yes, please provide:

Name of insurance company:

Group/Policy/Plan Number:

Policy holder's name:

Policy holder's date of birth:

ID or certificate number:

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PATIENT INFORMATION

Family Physician: Phone #: Date of last visit:

Other Specialist: Phone #: Date of last visit:

How did you find out about our office? (Select all that apply)

- ☐ Referral
- ☐ Online Search
- ☐ Live Locally
- ☐ Office Signage
- ☐ Newspaper
- ☐ Social Media
- ☐ Postcard
- ☐ Other

Whom may we thank for referring you:

PLEASE SIGN UPON COMPLETION:

I certify that I have provided an accurate and complete personal and medical-dental history below and have not knowingly omitted any information. I agree to inform this office of any changes in my medical or dental history. I have read and understand this paragraph, and I authorize Dr. Kinga Baskai, associates and staff to perform diagnostic procedures and treatment as may be necessary for dental care.

I hereby give Dr. Kinga Baskai, associates and/or staff permission to release information concerning my dental health to medical doctors, dentists or other specialists as deemed necessary for consultation and treatment. Such information includes radiographs (x-rays) and other diagnostic records that pertain to my oral health, initial condition, proposed treatment or treatment in progress.

Patient Signature **Doctor Signature** **Date**

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MEDICAL HISTORY

Do you currently have any health conditions? ◯ Yes ◯ No
(If yes, please explain)

Have you had any serious illnesses / hospitalizations in the past 2 years? ◯ Yes ◯ No
(if yes, please explain)

When was your last medical check up?

Do you currently have, or have you ever been treated for the following:

☐ Diabetes	☐ Artificial Joints (Hip, Knee)	☐ Liver Disease	☐ Nervous Disorders
☐ High blood pressure	☐ Arthritis/Arthrosis	☐ Kidney Disorder	☐ Fainting or Dizziness
☐ Angina	☐ Tuberculosis	☐ Glandular Problems	☐ Frequent Headaches
☐ Stroke	☐ Pulmonary/Respiratory/COPD	☐ Thyroid Disease	☐ Epilepsy
☐ Heart Murmur	☐ Asthma	☐ Osteoporosis	☐ Cancer
☐ Mitral Valve Prolapse	☐ Blood Diseases	☐ Emotional Problems	☐ Fibromyalgia
☐ Artificial Heart Valve	☐ Prolonged Bleeding	☐ Anxiety	☐ Multiple Sclerosis
☐ Heart Pacemaker	☐ Anemia	☐ Crohn's Disease	☐ Other (Please specify)
☐ Heart Attack	☐ HIV / Aids	☐ Psychiatric Disorder	
☐ Rheumatic Fever	☐ Hepatitis A, B or C	☐ Autism	

If you checked any of the above, please give details

List any medication, non- prescription drug or supplement now being taken:

1. 2. 3. 4.

5. 6. 7. 8.

List any allergies, drug allergies or sensitivities:

Please bring a recent medication list if extensive.

Do you smoke or chew tobacco products? ◯ Yes ◯ No If yes, how much per day?

Do you use recreational or medicinal drugs? (cannabis, cocaine, heroine, etc.) ◯ Yes ◯ No

Have you ever reacted adversely to any of the following medications or injections? (Select all that apply)

☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Local or general anesthetic ☐ Other

Are you allergic to Latex? ◯ Yes ◯ No

WOMEN: Are you pregnant? ◯ Yes ◯ No Breast feeding? ◯ Yes ◯ No

Have you ever needed monthly injections or oral bisphosphonate treatment for osteoporosis? ◯ Yes ◯ No

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Dental History

Date of last dental visit: Date of last dental cleaning: Date of last dental x-rays:

Are you having any pain or acute dental problem? ◯ Yes ◯ No

Have you ever had any of the following: oral surgery, periodontal treatment, orthodontic treatment, dental implants or any other dental surgery? ◯ Yes ◯ No
Specify:

Are any of your teeth sensitive to: ☐ cold ☐ sweet ☐ heat ☐ pressure ☐ chewing ☐ other

Do you have difficulty in chewing your food? ◯ Yes ◯ No

Does food catch between your teeth? ◯ Yes ◯ No

Do you notice any loose teeth or shifting of teeth? ◯ Yes ◯ No

Do you have any particular oral habits (eg. nail biting, lip biting, objects)? ◯ Yes ◯ No

Do you have frequent canker or cold sores? ◯ Yes ◯ No

Are you a mouth breather? While asleep? While awake? ◯ Yes ◯ No

Do you snore or have you been diagnosed with sleep apnea? ◯ Yes ◯ No

Do you grind or clench your teeth? ◯ Yes ◯ No

Do you have/ever had a nightguard, retainer or other oral appliance? ◯ Yes ◯ No

Have you ever experienced any of the following jaw/joint related problems:

Difficulty opening or closing ◯ Yes ◯ No

Popping and/or clicking in your jaw joint ◯ Yes ◯ No

Pain in your jaw joint, around your ear or side of your face ◯ Yes ◯ No

Frequent headaches ◯ Yes ◯ No

Do you gag easily? ◯ Yes ◯ No

Have you ever been advised to take antibiotics before dental treatments? ◯ Yes ◯ No

How often do you brush your teeth per day?

Do you use cleaning aides: ☐ Floss ☐ waterpik ☐ toothpick ☐ other

Do your gums bleed when brushing or eating? ◯ Yes ◯ No

Are you happy with the appearance of your teeth? ◯ Yes ◯ No
What would you like changed?

Are you apprehensive towards dental visits? ◯ Yes ◯ No

Do you have any other concerns we should be made aware of? ◯ Yes ◯ No