Tam Orthodontics and Pediatric Dentistry

CONFIDENTIAL

Patient Medical/Dental History Form for Adult Patients

Date: _____

Patient Last Name: _____ Patient First Name: _____

Preferred Name: _____

Gender: F☐ M☐ Other ☐ Birth Date: _____ Marital Status: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Cell Phone: _____ E-Mail: _____

PHN #: _____ Status #: _____

Referred by: _____

Occupation: _____ Employer: _____

Dental Insurance Information (if applicable):

Primary Policy Holder's Name: _____ Birth Date: _____

Employer: _____

Insurance Company: _____ Policy Plan #: _____

Subscriber ID: _____

Secondary Policy Holder's Name: _____ Birth Date: _____

Employer: _____

Insurance Company: _____ Policy Plan #: _____

Subscriber ID: _____

Closest Relative:

Spouse or relative's name: _____

Relationship to patient: _____

Address (if different from patient) _____

Cell phone: _____ Home phone: _____

Work phone: _____

Dr. Isaac Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Samuel Tam
MSc, DMD, FRCD (C)
Certified Specialist in Pediatric Dentistry and Orthodontics

Dr. Timothy Tam
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Certified Specialist in Pediatric Dentistry

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Dentist/Physician:

Patient's Dentist: _____ City: _____

Last Seen: _____ Reason: _____

Next Appointment: _____

Other dentist/dental specialists seen now - Name: _____

Reason: _____

Family Physician:

Physician Name: _____ City: _____

Last Seen: _____ Reason: _____

Other medical/health care providers seen now - Name: _____

Reason: _____

General Information:

What concerns you about your teeth? _____

How do you feel about dental or orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe _____

Have any other family members been treated in this office? Please name them: _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain.

_____

Do you chew or smoke tobacco? _____

Patient Health Information:

Do you take antibiotic pre-medication before any dental procedures? _____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

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Medical History: (Please check if you have any of the following)

- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Asthma/Sinus problems
- ☐ Tuberculosis
- ☐ Emotional Disorders
- ☐ Cancer/Tumour
- ☐ Immune System Problems
- ☐ Liver Disease
- ☐ Blood Disorders
- ☐ Bleeding Problems
- ☐ Kidney Disease
- ☐ Premature Birth
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Seizures, fainting spells or neurologic problems?
- ☐ Excessive bleeding or bruising tendency
- ☐ Eczema
- ☐ Skin Disorders
- ☐ Blood Transfusion
- ☐ Meningitis
- ☐ High or low blood pressure
- ☐ Stomach ulcers, hyperacidity, acid reflux

Do you have any other health problems? Yes: ☐ No: ☐

Please explain: _____

Have you ever been hospitalized? Yes: ☐ No: ☐

Please explain: _____

Do you have any Allergies? (food, medication, etc.)

- ☐ Latex (gloves, balloons)
- ☐ Metals (jewelry, clothing snaps)
- ☐ Acrylics
- ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ Aspirin
- ☐ Ibuprofen (Motrin, Advil)
- ☐ Penicillin
- ☐ Other antibiotics _____
- ☐ Plant Pollens
- ☐ Animals
- ☐ Foods
- ☐ Other substances _____

Dental History:

Now or in the past, have you had (please check the following):

- ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ Supernumerary (extra) or congenitally missing teeth?

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- ☐ Chipped or injured primary or permanent teeth?
- ☐ Bleeding gums, bad taste or mouth odour?
- ☐ Any sensitive or sore teeth?
- ☐ Jaw fractures, cysts, infections?
- ☐ Any teeth treated with root canals or pulpotomies?
- ☐ "Gum boils", frequent canker sores or cold sores?
- ☐ History of speech problems or speech therapy?
- ☐ Difficulty breathing through nose?
- ☐ Mouth breathing habit or snoring at night?
- ☐ Food impaction between the teeth?
- ☐ Frequent oral habits (sucking finger, chewing pen, etc.)?
- ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ Abnormal swallowing (tongue thrust)?
- ☐ Tooth grinding or clenching?
- ☐ Clicking, locking in jaw joints?
- ☐ Soreness in jaw muscles or face muscles?
- ☐ Ringing in ears, difficulty in chewing or opening jaw?
- ☐ Have you been treated for "TMJ" or "TMD" problems?
- ☐ Any broken or missing fillings?
- ☐ Any serious trouble associated with previous dental treatment? Please explain: _____
- ☐ Have you ever been diagnosed with gum disease or pyorrhea?
- ☐ Have you ever had an orthodontic consultation or treatment before now?

How often do you brush? _____ **Floss?** _____

Release and Waiver:

I, _____, being (self) of the above named patient hereby, give consent to Dr. Timothy/Isaac/Samuel Tam to perform treatments, operations, sedation and anesthesia that may be necessary to maintain optimum oral health.

Date: _____ Signature: _____

I authorize release of any information regarding my dental treatment to my dental insurance company.

Date: _____ Signature: _____

I have read the above questions and understand them. 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 will notify my dentist of any changes in my medical or dental health.

Date: _____ Signature: _____

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