Victoria Road
PERIODONTAL ASSOCIATES

Dr. Aditya Patel
Dr. Kristi Stefanison
Dr. Terrie Logue
Dr. Matthew Morris

NAME ..... BIRTHDATE: D..... M .....Y..... MARITAL STATUS .....

ADDRESS ..... CITY ..... POSTAL CODE .....

PHONE (H) ..... (B) ..... (C) .....

EMAIL .....

PREFERRED NAME ..... OCCUPATION .....

EMPLOYER ..... SCHOOL .....

PHARMACY NAME .....

NAME OF SPOUSE (OR GUARDIAN) ..... PHONE .....

NAME OF DENTIST ..... HOW LONG .....

NAME OF PHYSICIAN ..... HOW LONG .....

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? .....

REASON FOR VISIT .....

N.S. HEALTH CARD NO. .....

DO YOU HAVE DENTAL INSURANCE? ..... YOUR DENTAL INSURANCE COMPANY'S NAME .....

POLICY HOLDER'S NAME ..... BIRTHDATE: D..... M .....Y .....

EMPLOYER NAME .....

POLICY / GROUP # ..... CERTIFICATE / ID # .....

DO YOU HAVE SECONDARY INSURANCE? ..... COMPANY NAME .....

POLICY HOLDER'S NAME ..... BIRTHDATE: D..... M .....Y .....

EMPLOYER NAME .....

POLICY / GROUP # ..... CERTIFICATE / ID # .....

DENTAL HISTORY

Date of most recent dental exam _____
Date of most recent dental cleaning _____
How often (months) do you attend your hygiene/cleaning appointments? ..... ❑ 3 ❑ 6 ❑ 9 ❑ yearly

What is your immediate concern with regards to your teeth and gums? _____

Have you had any periodontal treatment in the past? ..... ❑ YES ❑ NO
If so, what was done? _____

Have you ever had complications from past dental treatment? ..... ❑ YES ❑ NO
Are you fearful of dental treatment? ..... ❑ YES ❑ NO
How fearful, on a scale of 1 (least) to 10 (most) _____
If you are anxious, would you prefer use of sedation to make your experience more relaxing? ..... ❑ YES ❑ NO
If so, what level of sedation are you interested in?
❑ Mild (oral sedative) ❑ Moderate (Oral + Nitrous) ❑ Deep Moderate (IV sedation)

Do you use a powered toothbrush? ..... ❑ YES ❑ NO
Do you currently use an inter-dental aids (proxy brush, flossing, superfloss etc.) ..... ❑ YES ❑ NO

Do you currently experience any of the following (check all that apply):
- ❑ Bleeding gums
- ❑ Bad Breath/Taste
- ❑ Receding gums
- ❑ Cold/Hot/Sweet sensitivity
- ❑ Food trap between teeth
- ❑ Loose teeth
- ❑ Jaw pain (clicking, sore on opening etc.)
- ❑ Clenching/grinding
- ❑ Headache/migraine upon waking

Do you currently (or in the past) have any of the following:
- ❑ Orthodontics/Braces
- ❑ Endodontic/Root Canal
- ❑ Crowns/Bridges
- ❑ Dental implants
- ❑ Partial Dentures
- ❑ TMD or Bite problems
- ❑ Bite plane/Night guard

Anything else in your dental history we should know? _____

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HEALTH HISTORY - CONFIDENTIAL

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Periodontal disease is produced by a combination of many complex elements. Although some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.

MEDICAL QUESTIONNAIRE

Are you in good health? ❑ YES ❑ NO

Date of last physical examination ..... Are you being treated by a physician now? ❑ YES ❑ NO

Blood pressure ..... Pulse ..... ❑ YES ❑ NO

Have you had excessive bleeding requiring special treatment? ..... ❑ YES ❑ NO

Have you had surgery within the last (5) five years? ..... ❑ YES ❑ NO

Have you ever had any of the following conditions? **IF YES, PLEASE ✓**

Cardiovascular Conditions
- ❑ Blood Pressure (High or Low)
- ❑ Heart Attack
- ❑ Heart Disease or Failure
- ❑ Heart Murmur
- ❑ Congenital Heart Lesions
- ❑ Angina Pectoris
- ❑ Rheumatic Heart Disease
- ❑ Heart Pacemaker
- ❑ Artificial Heart Valve
- ❑ Heart Surgery
- ❑ Swelling of Ankles
- ❑ Chest Pain
- ❑ Stroke

Respiratory Conditions
- ❑ Asthma
- ❑ Sinus Trouble
- ❑ Shortness of Breath
- ❑ Tuberculosis (TB)
- ❑ Emphysema

Endocrine Conditions
- ❑ Diabetes (Type 1 or Type 2)
- ❑ Thyroid Disorder (Hyper or Hypo)
- ❑ Parathyroid Disorder (Hyper or Hypo)

Blood Conditions
- ❑ Sickle Cell Disease
- ❑ Hemophilia (A or B)
- ❑ Anemia
- ❑ Bleeding/Coagulation Disorder
- ❑ Bruise Easily

Genito-Urinary Conditions
- ❑ Sexually Transmitted Disease (STD)
- ❑ Genital Herpes
- ❑ Kidney Disease

Immune Conditions
- ❑ HIV/AIDS
- ❑ Allergies or Hives
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Chemotherapy
- ❑ Radiation Therapy

Gastro-Intestinal Conditions
- ❑ Inflammatory Bowel Disease (IBD)
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Stomach Ulcers
- ❑ Acid Reflux

Neurological Conditions
- ❑ Epilepsy
- ❑ Seizures
- ❑ Psychosis
- ❑ Depression

OTHER
- ❑ Fainting
- ❑ Arthritis
- ❑ Liver Disease
- ❑ Hepatitis
- ❑ Cold Sores
- ❑ Cancer _____
- ❑ Osteoporosis
- ❑ Artificial Joint
- ❑ _____

List of all medications (including herbal), supplements, and or vitamins

Drug	Purpose	Drug	Purpose

Do you have allergies to or reacted adversely to any of the following medications?
- ❑ Local Anaesthesia ❑ Sulfa drugs ❑ Sedatives, sleeping pills ❑ Aspirin
- ❑ Penicillin ❑ Other antibiotic_____ ❑ NSAIDs (Advil, Naproxen etc.) ❑ Codeine or narcotics

Do you currently smoke? ..... ❑ YES ❑ NO
- ❑ Type --Cigarettes, Cigars, E-cigarettes/Vapor, Waterpipe (Hookah), Marijuana/Cannabis, Other_____
- ❑ How much (pack) per day?__
- ❑ For how many years?____

Did you smoke in the past? ..... ❑ YES ❑ NO
When did you quit? _____

Do you drink alcoholic beverages? ..... ❑ YES ❑ NO
How many per week?_____

Do you use illicit drugs (cocaine, heroin, ectasy etc.) ❑ YES ❑ NO

WOMEN:
Are you pregnant? ..... ❑ YES ❑ NO
Menopause? ..... ❑ YES ❑ NO

Is there anything else in your health history we should know? _____

SIGNATURE OF PATIENT (PARENT) ..... DATE: .....

REVIEWED BY ..... DATE: .....

Privacy and Consent Information Statement

Effective Date: 1 January 2023

Personal Information

"Personal Information" for our purposes is that information necessary for the provision of professional oral health care services to you. This includes all information that is provided by you on your patient information / medical health history form at the first and subsequent visits. It may also include information provided by you during the normal course of communication with our dental office staff.

Information Protection

We have established and implemented a variety of security measures to properly manage and safeguard your personal information from loss, theft and unauthorized access.

Digital Photos

As part of your treatment, photos will be taken to establish pre-surgical baseline and to compare final healing. Such photographs will be shared with your referring dentist. These photos are stored in secured format using encrypted password.

Information Disclosure

Your personal information shall be disclosed to only those who have a need to know. These include dentists, physicians and dental benefit providers. Personal information disclosed to the dental benefit providers is limited to that required by the provider.You may at any time designate restrictions on disclosure.

Information Retention and Destruction

Personal information will be retained for the period necessary to provide oral health services to you and for its related administration. This information will be destroyed in a secure manner when it is no longer required.

Your Access to Records

You may at any time ask to see your records held by us and to request amendments to that information.We will provide access within a reasonable timeframe.

Acknowledgement

Having read and understood the privacy statement for patients, I consent to the collection, use and disclosure of my personal information as presented in the statement, subject to the restrictionsidentified below.

No Restrictions .....

Restricted Access .....

My personal information shall not be provided to the following individuals or organizations:

.....

.....

.....

.....

Signature: ..... Date: .....

Complaint Process and Contact

Should you have any questions, comments or concerns, please bring them to the attention of the privacy officer.

Sincerely,

Dr. Aditya B. Patel **Dr. Kristi Stefanison** **Dr. Terrie Logue** **Dr. Matthew Morris**