Ultima DENTAL wellness
#202, 506 – 71 Avenue SW, Calgary, Alberta T2V 4V4
info@ultimadentalwellness.ca
(403) 259 – 3401

NEW PATIENT, DENTAL & MEDICAL HISTORY FORM

PERSONAL INFORMATION							
Last Name		First Name		Initial		Preferred Name	
Birthday		Male ☐	Female ☐	Single ☐	Married ☐	Child ☐	Other ☐
Address				City		Postal Code	
Cell Phone				Home Phone			
Bus Phone		Extension		E-Mail			
Family Physician				Telephone			
Emergency Contact Name				Emergency Contact Number			
Occupation							
How did you hear about our office?				Other			

INSURANCE INFORMATION							
Primary Insurance Information							
Name of Insured			Birthday		Employer		
Name of Insurance Co		Policy #		ID #		Div #	
Secondary Insurance Information							
Name of Insured			Birthday		Employer		
Name of Insurance Co		Policy #		ID #		Div #	

DENTAL HISTORY					
How would you rate the condition of your mouth?	Good ☐	Fair ☐	Poor ☐	Previous Dentist	
Date of most recent dental exam			Date of most recent x-rays		
What is your immediate concern?					

PLEASE CHECK TO ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS:

PERSONAL HISTORY	
1. Are you fearful of dental treatment?	☐
2. Have you had an unfavorable dental experience?	☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐
4. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐

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GUM AND BONE	
5. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐
6. Have you ever noticed an unpleasant taste or odor in your mouth?	☐
7. Is there anyone with a history of periodontal disease in your family?	☐
8. Have you ever experienced gum recession?	☐
TOOTH STRUCTURE	
9. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐
10. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐
11. Do you have grooves or notches on your teeth near the gum line?	☐
12. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐
13. Do you frequently get food caught between any teeth?	☐
BITE AND JAW JOINT	
14. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐
15. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐
16. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐
17. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐
18. Are your teeth developing spaces or becoming more loose?	☐
19. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐
20. Do you place your tongue between your teeth or close your teeth against your tongue?	☐
21. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐
22. Do you clench or grind your teeth together in the daytime or make them sore?	☐
23. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐
24. Do you wear or have you ever worn a bite appliance?	☐
SMILE CHARACTERISTICS	
25. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐
26. Have you ever whitened (bleached) your teeth?	☐
27. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐
28. Have you been disappointed with the appearance of previous dental work?	☐

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MEDICAL HISTORY					
Name of Physician					
Most recent physical examination					
How would you rate your current physical health?	Good ☐	Fair ☐	Poor ☐		
DO YOU HAVE or HAVE YOU EVER HAD:					
1. Hospitalization for illness or injury?					☐
2. An allergic or bad reaction to any of the following:					☐
Aspirin ☐	Codeine ☐	Penicillin ☐	Erythromycin ☐	Sulfa ☐	Local Anesthetic ☐
Metals (Nickel, Gold, Silver)					
Latex ☐	Peroxide ☐	Iodine ☐	Other ☐		
3. Heart problems, or cardiac stent within the last six months?					☐
4. Artificial heart valve, repaired heart defect (PFO)?					☐
5. History of infective Endocarditis?					☐
6. Pacemaker or implantable defibrillator?					☐
7. Orthopedic or soft tissue implant (e.g joint replacement, breast implant)?					☐
8. Heart murmur?					☐
9. Rheumatic or scarlet fever?					☐
10. High blood pressure?					☐
11. Low blood pressure?					☐
12. Stroke (taking blood thinners)?					☐
13. Anemia or other blood disorder?					☐
14. Prolonged bleeding due to slight cu (INR 3.5)?					☐
15. Kidney disease?					☐
16. Liver disease or jaundice?					☐
17. Thyroid, parathyroid disease, or calcium deficiency?					☐
18. Diabetes? (if yes which type)					☐
19. Viral infections and cold sores?					☐

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20. Hepatitis? (if yes which type)	☐
21. HIV/AIDS?	☐
22. Radiation therapy, cancer, or chemotherapy?	☐
ARE YOU:	☐
23. Are you presently being treated for any other illness?	☐
24. Are you a smoker?	☐
25. Do you have Glaucoma?	☐
26. Do you have sleep problems? (if yes please elaborate)	☐
27. Are you taking birth control pills?	☐
28. Are you currently pregnant?	☐
29. Currently nursing?	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years			
Drug Name 1		Purpose	
Drug Name 2		Purpose	
Drug Name 3		Purpose	
Drug Name 4		Purpose	

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Print Patient Name		Date	
Signature			