HAREWOOD DENTAL

Dr. Katharine Gillanders and Associates

Legal Name: _____

Pref Name: _____ **Gender:** M ☐ F ☐ O ☐ **Birth Date:** (MM/DD/YY) _____

Parent(s) / Guardian Name(s) (if minor): _____

Mailing Address: _____

City & Province: _____ **Postal Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Best Number for Contact: Home ☐ Work ☐ Cell ☐

Email Address (for appointment reminders): _____

Emergency Contact (Name & Phone #): _____

HAREWOOD DENTAL POLICIES

INITIAL

Appointment Reminders:
We understand that you are booking appointments in advance and schedules can get busy. Reminders are sent one week and two business days ahead of your appointment via text message and/or email, which you can confirm by following the instructions in the message. If no response is received, we will call you and require your appointment to be confirmed by the day prior. ☐

Cancellation Policy:
Once you have made your appointment, this time has been reserved exclusively for you. We require 24 hours notice should you need to reschedule your appointment or $50 fee will be payable. There is an automatic $100 fee for all missed appointments that were not cancelled. ☐

Financial Policy:
Payment is due on the day of your appointment. ☐

Insurance estimates are not a guarantee of payment.

Dental plans are a contract between you and your insurance company. Harewood Dental is a 3rd party who submits claims and collects payments on your behalf – you are fully responsible for any payment not made by your insurance company. If your insurance can not be confirmed as active then full payment is required and we will provide you with the appropriate documents for reimbursement.

I have read and understand the above policies. I recognize that the information on these forms is confidential information shared only between myself and the appropriate dental professionals involved in my care.

Date: _____ **Patient** (or Guardian) **Signature:** _____

MEDICAL HISTORY

Patient name: _____

Physician name/phone #: _____

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury _____	☐	☐
2.	an allergic or bad reaction to any of the following:	☐	☐
	○ aspirin, ibuprofen, acetaminophen, codeine _____		
	○ penicillin _____		
	○ erythromycin _____		
	○ tetracycline _____		
	○ sulfa _____		
	○ local anesthetic _____		
	○ fluoride _____		
	○ chlorhexidine (CHX) _____		
	○ Iodine _____		
	○ metals (nickel, gold, silver, _____)		
	○ latex _____		
	○ nuts _____		
	○ fruit _____		
	○ milk _____		
	○ red dye _____		
	○ other _____		
3.	heart problems, or cardiac stent within the last six months _____	☐	☐
4.	history of infective endocarditis _____	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6.	pacemaker or implantable defibrillator _____	☐	☐
7.	orthopedic or soft tissue implant (e.g., joint replacement, breast implant) _____	☐	☐
8.	heart murmur, rheumatic or scarlet feve _____	☐	☐
9.	high or low blood pressure _____	☐	☐
10.	a stroke (taking blood thinners) _____	☐	☐
11.	anemia or other blood disorder _____	☐	☐
12.	prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13.	pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14.	chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15.	breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion)	☐	☐
16.	sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	☐	☐
17.	kidney disease _____	☐	☐
18.	liver disease or jaundice _____	☐	☐
19.	vertigo (e.g., "the room is spinning") _____	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21.	hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	☐	☐
22.	high cholesterol or taking statin drugs _____	☐	☐
23.	diabetes (HbA1c = _____) _____	☐	☐
24.	stomach or duodenal ulcer _____	☐	☐
25.	digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	☐	☐
26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	☐	☐
27.	arthritis or gout _____	☐	☐
28.	autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29.	glaucoma _____	☐	☐
30.	contact lenses _____	☐	☐
31.	head or neck injuries _____	☐	☐
32.	epilepsy, convulsions (seizures) _____	☐	☐
33.	neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease)	☐	☐
34.	viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____	☐	☐
35.	any lumps or swelling in the mouth _____	☐	☐
36.	hives, skin rash, hay fever _____	☐	☐
37.	STI/STD/HPV _____	☐	☐
38.	hepatitis (type ____) _____	☐	☐
39.	HIV/AIDS _____	☐	☐
40.	tumor, abnormal growth _____	☐	☐
41.	radiation therapy _____	☐	☐
42.	chemotherapy, immunosuppressive medication _____	☐	☐
43.	difficulties with stress management _____	☐	☐
44.	psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45.	concentration problems or ADD/ADHD _____	☐	☐
46.	alcohol/recreational drug use _____	☐	☐

ARE YOU:

		YES	NO
47.	presently being treated for any other illness _____	☐	☐
48.	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49.	taking medication for weight management _____	☐	☐
50.	taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51.	often exhausted or fatigued _____	☐	☐
52.	experiencing frequent headaches or chronic pain _____	☐	☐
53.	a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54.	considered a touchy/sensitive person _____	☐	☐
55.	often unhappy or depressed _____	☐	☐
56.	taking birth control pills _____	☐	☐
57.	currently pregnant _____	☐	☐
58.	diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, mobility issues, or other treatment that may possibly affect your dental treatment: _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years: _____

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

Patient's signature: _____ Date: _____

Doctor's signature: _____ Date: _____

DENTAL HISTORY

Patient name: _____

Previous dentist name/clinic/phone #: _____

Date of most recent dental appointment: ____ /____ /____ Date of most recent x-rays: ____ /____ /____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely ☐ First dental visit

WHAT IS YOUR IMMEDIATE/PRIMARY CONCERN:_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE			
7.	Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8.	Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13.	Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐
TOOTH STRUCTURE			
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐	☐
16.	Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT			
21.	Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
22.	Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34.	Have you ever bleached (whitened) your teeth?	☐	☐
35.	Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐