Park Street Dentistry
6 Park Street North,
Peterborough, ON
K9J 3V2
(705) 742-7472

CONFIDENTIAL PATIENT HISTORY FORM

Welcome to our Dental Office! Provide as much information as possible to allow us to plan appropriate dental care for you. All personal information is confidential and protected.

Patient ID _____

Last Name _____ Birth Date Month ▼ Day ▼ Year _____

First Name _____ Title ▼

Address _____

Home Phone _____ Cell Phone _____ Office Phone _____

Email address _____

Employer _____ Occupation _____

Whom may we thank for referring you to our office? _____

In case of emergency Notify _____ Relation _____ Phone _____

Primary Insurance		Secondary Insurance	
Subscriber		Subscriber	
Relation		Relation	
Insurance Co.		Insurance Co.	
Policy/ Plan #		Policy/ Plan #	
Division/Section #		Division/Section #	
Subscriber ID		Subscriber ID	
SIN		SIN	

Insurance notes _____

Dental History

Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other Specify _____

Are you having dental pain? ▼ Any specific dental problem? _____

How often do you see the dentist? ☐ 6 months ☐ Yearly ☐ Other Frequency _____

Former Dentist _____ Last Dental Visit _____ Last cleaning _____

How often do you brush your teeth? _____ Floss _____

Do your gums bleed easily? ▼ Are your teeth sensitive to: ☐ Cold ☐ Sweet ☐ Hot ☐ Biting/Chewing

Do you feel you have bad breath sometimes? ▼ Have you ever had jaw surgery? ▼

Do you have pain in your jaws ? ▼ Chronic Headaches ? ▼ Any part of your jaw hurt when you clench? ▼

Does your jaw crack or pop when you open widely? ▼ Do you grind or clench your teeth during the day or night? ▼

Have you ever had?: ☐ Root Canal ☐ Braces ☐ Gum Surgery ☐ Oral Surgery ☐ Canker Sores

Do you smoke? ▼ How many per day? _____ Do you or any family member have snoring or sleep apnea problems? ▼

Had Previous problems with dental care? Explain _____

Are you satisfied with appearance of your teeth? Explain _____

Other Dental Concerns: _____

I certify that I have provided an accurate and complete personal and medical history and have not knowingly omitted any information. I understand that the dentist may contact my physician if required and I consent to my physician being contacted. I authorize the dentist to provide dental care for me.

Signature of Patient _____ Date _____