Welcome to Tuscany Dental Centre

The benefits of a happy, beautiful smile are immeasurable! Our goal is to help you reach and maintain your oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

○ Male ○ Female

○ Dr ○ Mr ○ Mrs ○ Ms

Name: First: _____

Middle: _____

Last: _____

I Prefer to be called: _____

Home Address: _____

City: _____

Postal Code: _____

Date of Birth: (Month/Day/Year): _____

Home Tel: _____

Work Tel: _____

Cell Number: _____

Email: _____

Spouse Name: _____

Referred to this office by: _____

Insurance:

1st Insurance Company: _____ **2nd** Insurance Company: _____

Policy Holder: _____ Policy Holder: _____

Employer: _____ Employer: _____

Group / Policy#: _____ Group / Policy#: _____

I.D#: _____ I.D#: _____

DOB (m/d/y): _____ DOB (m/d/y): _____

Privacy Information

How we collect, use and disclose your information:
When you do business with us you share personal information so that we may provide you with the treatment, services, and products that best meet your needs. We assure your consent for our office to use this information in an appropriate manner – to evaluate and process insurance claims and to detect and prevent fraud. We do not sell client information. All employees, associated advisors and insurance companies who are granted access to client records understand the need to keep this information protected and confidential. You may withdraw your consent at any time – by providing us with 30 days notice by contacting our office at (403)239-0010. Please be aware that withdrawing your consent may prevent us from providing you with requested treatment or services. Your appointment time is reserved especially for you. If you are unable to keep this time we require 48 hours notice to reschedule. I hereby assign my benefits, payable from claims submitted electronically to Dr Cam Brauer / Dr Scott Townsend and authorize payment directly to him. This authorization shall continue in effect until the undersigned revokes the same.

Signature: _____ Date: _____

Medical History

Name of Physician / and their speciality _____

Most recent physical examination _____

Purpose _____

What is your estimate of your general health?

○ Excellent ○ Good ○ Fair ○ Poor

List any medications, supplements, and or vitamins taken within the last two years

_____

_____

_____

Do You Have or Have You Ever Had:

1. hospitalization for illness or injury _____ ○ Yes ○ No
2. an allergic reaction to _____

- ○ aspirin, ibuprofen, acetaminophen
- ○ penicillin
- ○ erythromycin
- ○ tetracycline
- ○ codeine
- ○ local anesthetic
- ○ fluoride
- ○ metals (gold, stainless steel)
- ○ latex
- ○ any other medications

3. diarrhea, persistent cough or undiagnosed skin rash _____ ○ Yes ○ No
4. heart problems _____ ○ Yes ○ No
5. heart murmur _____ ○ Yes ○ No
6. rheumatic fever _____ ○ Yes ○ No
7. scarlet fever _____ ○ Yes ○ No
8. high blood pressure _____ ○ Yes ○ No
9. low blood pressure _____ ○ Yes ○ No
10. a stroke _____ ○ Yes ○ No
11. artificial prosthesis (ie heart valve or joints) _____ ○ Yes ○ No
12. anemia or other blood disorder _____ ○ Yes ○ No
13. prolonged bleeding with a slight cut _____ ○ Yes ○ No
14. emphysema _____ ○ Yes ○ No
15. tuberculosis _____ ○ Yes ○ No
16. asthma _____ ○ Yes ○ No
17. breathing or sleep problems (ie snoring, sinus) _____ ○ Yes ○ No
18. kidney disease _____ ○ Yes ○ No
19. liver disease _____ ○ Yes ○ No
20. jaundice _____ ○ Yes ○ No
21. thyroid or parathyroid disease _____ ○ Yes ○ No
22. hormone deficiency _____ ○ Yes ○ No
23. high cholesterol _____ ○ Yes ○ No
24. diabetes _____ ○ Yes ○ No
25. stomach or duodenal ulcer _____ ○ Yes ○ No
26. digestive disorders (ie gastric reflux or celiac) _____ ○ Yes ○ No
27. osteoporosis / osteopenia (ie taking bisphosphonates) _____ ○ Yes ○ No
28. arthritis _____ ○ Yes ○ No
29. glaucoma _____ ○ Yes ○ No
30. contact lenses _____ ○ Yes ○ No
31. head or neck injuries _____ ○ Yes ○ No
32. epilepsy, convulsions (seizures), fainting _____ ○ Yes ○ No
33. Neurological problems _____ ○ Yes ○ No
34. viral infections and/or cold sores _____ ○ Yes ○ No
35. any lumps or swelling in the mouth _____ ○ Yes ○ No
36. hives, skin rash, hay fever _____ ○ Yes ○ No
37. venereal disease _____ ○ Yes ○ No
38. hepatitis (type ___) _____ ○ Yes ○ No
39. HIV / AIDS _____ ○ Yes ○ No
40. tumor, abnormal growth _____ ○ Yes ○ No
41. radiation therapy _____ ○ Yes ○ No
42. chemotherapy _____ ○ Yes ○ No
43. psychiatric treatment _____ ○ Yes ○ No
44. antidepressant medication _____ ○ Yes ○ No
45. alcohol / drug dependency _____ ○ Yes ○ No

ARE YOU:

46. presently being treated for any other illness _____ ○ Yes ○ No
47. aware of a change in your general health _____ ○ Yes ○ No
48. taking medication for weight management _____ ○ Yes ○ No
49. often exhausted or fatigued _____ ○ Yes ○ No
50. subject to frequent headaches _____ ○ Yes ○ No
51. a smoker or smoked previously _____ ○ Yes ○ No
52. FEMALE – taking birth control pills _____ ○ Yes ○ No
53. FEMALE – pregnant _____ ○ Yes ○ No
54. MALE – prostate disorders _____ ○ Yes ○ No

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____How long have you been a patient? _____Months / Years

Date of most recent dental exam_____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every: ☐ 3mths ☐ 4mths ☐ 6mths ☐ 12mths ☐ Not recently

What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? 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 reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing?_____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth _____ ☐ ☐
9. Have you ever noticed a unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _ ☐ ☐
13. Have you experienced a burning sensation 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 to little or do you have difficulty swallowing any food?_____ ☐ ☐
16. Do you feel or notice any holes (ie pitting, craters) on the biting surface of your teeth?_____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets or 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. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? __ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
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, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or rest 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 your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or any 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 teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) 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? _____ ☐ ☐

Doctors's Signature _____Date:_____

Patient's Signature _____Date:_____