



**Steven J. Deneka, B.Sc., D.D.S.**

Dental Surgeon

**Name** \_\_\_\_\_

Preferred Name \_\_\_\_\_

Married  Single  Other \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business Telephone \_\_\_\_\_ Ext. \_\_\_\_\_

Spouse \_\_\_\_\_

In case of emergency please notify \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

What can we do for you today? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Do you have any teeth that are sensitive to hot/cold/sweets/to bite on? \_\_\_\_\_

**Dental History**

**Y N Have you ever had:**

- Orthodontic Treatment (braces or retainer)?
- Oral Surgery (extractions)?
- Are you wearing any dentures?
- Special Gum Treatment?
- Root Canal and/or a Crown?
- Your bite adjusted?
- Do you clench or grind your teeth while awake or asleep?

**Y N Have you experienced:**

- Clicking of your jaw?
- Pain (Joint, ear, side of face)?
- Difficulty in opening or closing?
- Difficulty in chewing?
- Have you noticed any loosening of your teeth?  
Which ones? \_\_\_\_\_
- Does food tend to become caught between your teeth?  
Between which teeth? \_\_\_\_\_
- Do you often notice a bad taste in your mouth?
- Do your gums often bleed when you brush your teeth?
- Have you ever wanted to change the appearance of your smile?  
If so, how? \_\_\_\_\_
- Have you ever had difficulty with dental freezing?
- Is there anything about dentistry that makes you nervous?  
\_\_\_\_\_  
\_\_\_\_\_

**Chart #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Present Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

When was your last medical exam? \_\_\_\_\_

**Are you now taking any medication, drugs or pills of any kind?**

If yes, please list: \_\_\_\_\_

Are you allergic or have you reacted adversely to any medications? \_\_\_\_\_

**Medical History**

**Y N Do you have or have you had any of the following?**

- Artificial Heart Valve
- Major Joint Replacement
- Asthma
- Heart Pacemaker
- Heart Surgery
- High/Low Blood Pressure
- Heart Murmur
- Malignant Hyperthermia
- Rheumatic Fever
- Epilepsy or Seizures
- Fainting or Dizzy Spells
- Bruise Easily/Bleed Excessively
- Diabetes: Diet or medication controlled?
- Hepatitis A (infectious)
- Hepatitis B (serum)
- Has anyone suggested antibiotic coverage prior to treatment?
- HIV Positive
- Are you concerned about the precautions this office takes regarding infectious diseases?
- Are you pregnant? If yes, what month are you due? \_\_\_\_\_
- Any medical condition not mentioned above?

**Dental Insurance**  **None**  **Other**

Primary Insurance Company \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

**Your Spouse**

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ Business Telephone \_\_\_\_\_ Ext. \_\_\_\_\_

**Office Policies Reviewed:**

- Financial Arrangements
- Appointments
- Philosophy of our practice

Signature \_\_\_\_\_ Date \_\_\_\_\_

*I understand that the above questions directly relate to the quality of dental care I can expect to receive in this office. I have not knowingly withheld information that could complicate my treatment.*