Millennium Dental

403 236-4443

- Dr. Munira Jivraj
- Dr. Moez Lakhani
- Dr. Salima Shariff
- Dr. Veeta Maharaj

Personal Information

Name: ______________________________ Today's date: ______________________________

Address: ______________________________ Postal Code: ______________________________

Phone Home: ______________________________ Work: ______________________________ Cell: ______________________________

Date of Birth: ______________________________ Sex: M F **Email Address**: ______________________________

Employer: ______________________________ Occupation: ______________________________

Emergency Contact: ______________________________ Phone: ______________________________

Physician: ______________________________ Phone: ______________________________

Previous Dentist: ______________________________ Phone: ______________________________

HOW DID YOU HEAR ABOUT OUR CLINIC? ______________________________

Medical History

When did you last see your physician, and for what reason? ______________________________

Do you have any drug allergies that you are aware of? YES NO *(Please list:)* ______________________________

Do you have a Latex Allergy? YES NO

Have you ever been hospitalized? YES NO If Yes, for what reason? ______________________________

Did a dentist, physician or specialist ever recommend taking antibiotics prior to dental treatment or surgery? YES NO

Please list any Medications & Supplements you are taking: ______________________________

____

Please Check any of the following conditions that apply to you, past or present

☐ Anemia	☐ Diabetes	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Arthritis	☐ Drug Use	☐ High Blood Pressure	☐ Sinus problems
☐ Artificial Joints	☐ Epilepsy	☐ Jaundice	☐ Sleep Apnea
☐ Asthma	☐ Fainting	☐ Kidney disease	☐ Snoring
☐ Blood Disorders	☐ Gastrointestinal	☐ Liver problems	☐ Stroke
☐ Breathing Problems	☐ Growth or tumor	☐ Low Blood Pressure	☐ Surgery
☐ Cancer	☐ Heart Attack	☐ Mental/Nervous disorders	☐ Thyroid problems
☐ Clotting/Bleeding Problems	☐ Heart Disease	☐ Migraines/headaches	☐ Tuberculosis
☐ Cold Sores	☐ Heart Murmur	☐ Osteoporosis	☐ Ulcers
☐ Depression	☐ Hepatitis A - B - C	☐ Pacemaker	

WOMEN:

Are you pregnant? YES NO Birth Control Pills or HRT? YES NO Are you in peri-menopause or menopause? YES NO

TOBACCO:

Were you/are you a Smoker? YES NO If Yes, for how long? __________ How much?__________ Past/Future Quit Date:__________

Do you chew tobacco? YES NO

Is there anything else you would like us to know about your health? ______________________________

Appointment Policy:

We would like to ask for a minimum of ***2 BUSINESS DAYS NOTICE*** if for any reason you will be unable to keep a scheduled appointment. This consideration will allow us to accommodate those patients that may be waiting for an appointment.

For your convenience, we will continue to call or email you prior to your appointment to remind you and receive confirmation for your visit.

I, ______________________________ have read & understand the above policy. Date:______________________ Signature:______________________________

DENTAL HISTORY

What is your present dental concern? ____

Are any of your teeth sensitive or aching? YES NO Which tooth/area? ______________________________________

When was your last dental visit? ______________________ Last professional cleaning? ______________________________

Have you ever had any bad or good experiences at a dental office you would like to make us aware of? YES NO

What is your dental comfort level from **1** to **10**? *(Please circle)*: ***not comfortable*** 1 2 3 4 5 6 7 8 9 10 ***completely comfortable***

How often do you brush your teeth? ______________________________ Floss? __________________________________

Do you use: *(Please circle)*: Mouthwash / Toothpicks / Proxy-brush / Floss Threaders

Others *(Please list)*: ____

Have you noticed any bad breath, mouth odors or a bad taste in your mouth? YES NO

Does you mouth often seem dry? YES NO Do you notice bleeding when you brush? YES NO Floss? YES NO

Have you ever been diagnosed with: *(Please circle)*: Gingivitis / Gum Disease / Periodontal Disease / Deep Pockets

Any other condition related to the health of your gums? YES NO *(Please List)*: ______________________________________

Rate your SMILE from **1** to **10**? *(Please circle)*: *dislike my smile* 1 2 3 4 5 6 7 8 9 10 *love my smile*

What would you like to change or improve in your smile or your mouth in general? _______________________________________

THE FOLLOWING LIST OF SYMPTOMS CAN BE SIGNS OF TMJ/TMD OR BITE PROBLEMS. PLEASE CHECK ANY THAT MAY APPLY TO YOU

- ☐ Back/Neck pain
- ☐ Bell's Palsy
- ☐ Clenching
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Ear congestion
- ☐ Facial Pain
- ☐ Grinding
- ☐ Headaches
- ☐ Hot/Cold sensitivity
- ☐ Insomnia
- ☐ Joint popping/clicking
- ☐ Limited opening
- ☐ Loose teeth
- ☐ Ringing in the ears (Tinnitis)
- ☐ Tender/sensitive teeth
- ☐ Tingling in fingertips
- ☐ TMJoint pain
- ☐ Trigeminal Neuralgia

THE FOLLOWING LIST OF SYMPTOMS CAN BE SIGNS OF A SLEEP OR BREATHING DISORDER. PLEASE CHECK ANY THAT MAY APPLY TO YOU

- ☐ You have been told you snore
- ☐ You have been told you stop breathing in your sleep
- ☐ You have difficulty falling/staying asleep
- ☐ You wake up feeling unrested
- ☐ You feel tired or drowsy during the day
- ☐ Your nose feels stuffed up when you don't have a cold
- ☐ You have previously has a Sleep Study done
- ☐ You have been diagnosed with Sleep Apnea/UARS
- ☐ You wear or have been told to wear a CPAP
- ☐ You wake up with headache/sore face muscles

Is there anything you would like to make us aware of that has not been covered on this form? YES NO

(Please List): ____

PERMISSION TO TREAT/RELEASE OF INFORMATION/PRIVACY

This is to certify that I, the undersigned, consent to the performance of dental treatment agreed to be necessary or advisable by the Dentist. I will assume full responsibility for fees associated with treatment. I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same. I am aware the office has a Privacy Policy which I can view at any time

Date: ________________________ Signature of Patient/Parent/Guardian: ____

DENTAL INSURANCE

We are more than happy to help you with your insurance claims. Payment in full is required at the time of service. Whenever possible, we will electronically send your insurance claims which will speed up the process for you and you should receive your insurance reimbursement within a few short days.

Primary

Employer:_____________________________________ Provider:_______________________ Group #:___________________ I.D #_________________

Secondary

Employer:_____________________________________ Provider:_______________________ Group #:___________________ I.D #_________________

*If the insurance belongs to your spouse please add Name:*________________________________ *Birthday:*____________________