PANORAMA
DENTAL CARE

New Patient Form

Welcome to the Panorama Dental Care Family! Your co-operation in filling out the data on this confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain in the office.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ Gender: ☐ M ☐ F ☐ Other Married: ☐ Y ☐ N ☐ Widowed
day/month/year

Phone: _____ Secondary Phone: _____

Email: _____

Preferred Contact Method: ☐ Phone ☐ SecondaryPhone ☐ Email ☐ TextMessage

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ Province: _____ Postal code: _____

Home Phone: _____

Occupation: _____ Employer: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

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DENTAL HISTORY

Are you having any discomfort at this time? Yes ☐ No ☐

If yes, please specify: _____

_____

_____

Have you been under regular care of a dentist? Yes ☐ No ☐

When was your last dental visit?

What was done at that appointment?

Which of the following do you use?

Electric toothbrush	☐	String floss	☐	Other	☐
Manual toothbrush	☐	Floss Picks	☐		
Waterpik	☐	Interdental brushes	☐		

Do you clench and/or grind your teeth? Yes ☐ No ☐ Unsure ☐

Do you have a nightguard? Yes ☐ No ☐

Have you every been given local anesthetic (freezing)? Yes ☐ No ☐

Have you ever been given general anesthetic? Yes ☐ No ☐

Have you ever had any orthodontic work done? Yes ☐ No ☐

If yes, what was done and when? _____

Are you satisfied with the appearance of your smile? Yes ☐ No ☐

Would you prefer to keep your natural teeth? Yes ☐ No ☐

Are you tense/ nervous during dental visits? Yes ☐ No ☐

Describe what you would like done to your teeth, or any concerns you may have:

_____

_____

_____

Thank you for taking the time in filling out this form.
We look forward to seeing your at your first appointment!

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1380 Upper Canada
Suite 102, Kanata
613-836-6060

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New Patient Medical History

Name of Medical Doctor:

Emergency Contact Phone Relationship

List all medications that you are now taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other: _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Gluten	☐	☐	Peanuts
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other: _____

Do you have any/ have you been treated for any of the following medical conditions? Please specify in the space below:

☐ Asthma	☐ High Blood Pressure	☐ Sinus Trouble
☐ Bleeding Problems	☐ Joint Replacement	☐ Ulcers
☐ Cancer	☐ Sleep Apnea	☐ Rheumatic Fever
☐ Diabetes	☐ Kidney Disease	☐ Endocarditis
☐ Heart Murmur	☐ Liver Disease	☐ Osteoporosis
☐ Heart Trouble	☐ Pregnancy	☐ Other
☐ Stroke	☐ Psychiatric Treatment	

Details as needed:

Have you been hospitalized in the last 5 years? Y ☐ N ☐ If yes, please specify:

Tobacco use? If so, what kind and how much?

Cannabis use? If so, what kind and how much?

_____

Date: Signature:

please sign or type your name above

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TRANSFER OF RECORDS

Name :_____ DOB: _____

Please also include the records for my family members:

DOB:

Name of Previous Dental Clinic: _____

Phone Number:_____

Signature:_____ Date:_____

please sign or type your name above

Please send all valid radiographs and records to: info@panoramadentalcare.ca

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