WELCOME TO THE OFFICE OF
DR. DENNIS DIONNE

Patient's Name:_____

Age: _____ Birth date: _____(M/D/YR)

Address: _____ City: _____

Postal Code: _____ Home Phone #: _____ Work Phone #: _____

Parent email: _____ Patient email: _____

Emergency contact: (adults only) _____

Family Dentist: _____ Referred by: _____

Who is responsible for paying the bill?_____

Birth date: _____ Driver's License: _____ SIN:_____

Address: same as above OR _____ City: _____

Postal Code: _____ Home Phone #: _____ Work Phone #: _____

Any other family members currently a patient in our office? _____

Main reason you are seeking treatment: _____

DENTAL HISTORY:

Last time seen by family dentist? _____ Do any cavities exist? Y/N

Any history of blows/trauma to the face? _____

Do you know of any missing/extra permanent teeth? Y/N

Are there any sores, lumps, or irritated areas in the mouth? Y/N

Are there any speech problems? Y/N

Do any oral habits exist? ___thumb sucking ___teeth grinding
___nail biting ___mouth breathing

Has the patient had previous orthodontic treatment? _____

_____

Does the patient have any TMJ (jaw joint) problems? Y/N If yes, explain: _____

_____

Is there anything the patient would like to change about his/her smile? Y/N

If so, what? _____

(over)

MEDICAL HISTORY

Patient's Medical Doctor: _____

Is the patient's general health good at this time? Y/N

Is the patient under the care of a physician at this time? Y/N

If yes, explain: _____

Is the patient taking any medication at this time? Y/N

Name: _____

Any allergies? Y/N If yes, what? _____

Has the patient had tonsils and/or adenoids removed? Y/N

Age: _____

Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? Y/N

If yes, antibiotic name: _____

Does the patient smoke? Y/N

Any history of heart trouble, rheumatic fever, etc? Y/N

If yes, explain: _____

Any other medical conditions the doctor should be aware of? Y/N

If yes: _____

DATE: _____ **SIGNATURE:** _____

SIGNATURE: _____

Dennis G. Dionne

D.D.S., Cert. Ortho., FRCD(C)

IF ANY OF THIS INFORMATION EVER CHANGES, PLEASE INFORM US.

Thank You!!