Confidential Information Questionnaire

Dr. John Bjornson, Inc. #202 1964 Fort Street Victoria, BC Phone 250-595-3377

Patient Name

Last Name | First Name | Middle Name

Date of Birth | Sex | Marital Status

Sex: ○ M ○ F

Patient Address

Street | APT#

City | Province | Postal Code

Email Address | Home Phone Number

Patient Employer & Occupation

Employer | Occupation

Work Address

City | Province | Postal Code

Work Phone | Cell Phone

Okay to contact you at work?

☐ Yes ☐ No

Spouse Employer & Occupation

Employer

Occupation

Work Address

City

Province

Postal Code

Work Phone

Cell Phone

Okay to contact you at work?

☐ Yes ☐ No

Emergency Contact Information

Name of person we can contact in case of emergency - Not at your family home

Relationship

Home Phone Number

Work Phone Number

Cell Number

Thank you and Referrals

Other family members that are patients here?

Who can we thank for referring you to our office?

Insurance & Financial Information

Insurance Coverage?

◯ Yes

◯ No

Insurance Company

Insurance Company Address

Phone Number

City

Province

Subscriber's Name

Subscriber's Date of Birth

Patient's relationship to subscriber

Group/Program Number

Employer (If different from above)

Employer's Address (If different from above)

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.
In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.
I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: _____

Date: _____

MEDICAL HISTORY

Patient Name and Nickname (If Applicable)

Most Recent Physical Exam

Name of Physician

What is your estimate of your general health?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

DO YOU HAVE or HAVE YOU EVER HAD?

- ☐ hospitalization for illness or injury
- ☐ heart problems
- ☐ a stroke
- ☐ heart murmur
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ scarlet fever
- ☐ rheumatic fever
- ☐ artificial prosthesis (i.e. heart valve or joints)
- ☐ anemia or other blood disorder
- ☐ prolonged bleeding due to a slight cut
- ☐ emphysema
- ☐ tuberculosis
- ☐ asthma
- ☐ breathing or sleep problems (i.e. snoring, sinus)
- ☐ kidney disease
- ☐ liver disease
- ☐ jaundice
- ☐ thyroid or parathyroid disease
- ☐ hormone deficiency
- ☐ high cholesterol
- ☐ diabetes
- ☐ stomach or duodenal ulcer
- ☐ digestive disorders (i.e. gastric reflux)
- ☐ osteoporosis/osteopenia (i.e. taking bisphosphonates)
- ☐ arthritis
- ☐ glaucoma
- ☐ contact lenses
- ☐ head or neck injuries
- ☐ epilepsy, convulsions (seizures)
- ☐ neurologic problems
- ☐ viral infections and cold sores
- ☐ any lumps or swelling in the mouth
- ☐ hives, skin rash, hay fever
- ☐ venereal disease
- ☐ hepatitis (type A)
- ☐ hepatitis (type B)

DO YOU HAVE or HAVE YOU EVER HAD (Continued on next page...)

Do You Have or Have You Ever Had (continued from previous...)

- ☐ hepatitis (type C)
- ☐ HIV/AIDS
- ☐ Tumor or abnormal growth
- ☐ radiation therapy
- ☐ chemotherapy
- ☐ emotional problems
- ☐ psychiatric treatment
- ☐ antidepressant medication
- ☐ alcohol or drug dependency

ARE YOU?

Are you:

- ☐ presently being treated for any other illness
- ☐ aware of a change in your general health
- ☐ taking medication for weight management (i.e. fen-phen)
- ☐ taking dietary supplements
- ☐ often exhausted or fatigued
- ☐ subject to frequent headaches
- ☐ a smokerorsmoked previously
- ☐ considered a touchy person
- ☐ often unhappy or depressed
- ☐ FEMALE -taking birth control pills
- ☐ FEMALE - pregnant
- ☐ MALE -prostate disorders

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

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

Drugs	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ _____

Doctor's Signature: _____ _____

Dental History

Previous Dentist

How would you rate the condition of your mouth?

How long have you been a patient of your previous dentist?

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:

What is your immediate concern?

Dental History Questionnaire - Please answer yes or no to the following

Personal History

Are you fearful of dental treatment?

- ◯ Yes
- ◯ No

Are you fearful of dental treatment - On a scale of 1 to 10

	1	2	3	4	5	6	7	8	9	10
rating	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Have you had an unfavorable dental experience?

- ◯ yes
- ◯ no

Haveyou ever had complications from past dental treatment?

- ◯ yes
- ◯ no

Have you ever had trouble getting numb or reactions to local anesthetic?

- ◯ yes
- ◯ no

Did you ever have braces, orthodontic treatment or had your bite adjusted?

- ◯ yes
- ◯ no

Have you had any teeth removed?

- ◯ yes
- ◯ no

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change?

- ◯ yes
- ◯ no

Have you ever whitened (bleached) your teeth?

- ◯ yes
- ◯ no

Are you self conscious about your teeth?

- ◯ yes
- ◯ no

Have you been disappointed with the appearance of previous dental work

- ◯ yes
- ◯ no

BITE and JAW JOINT

Do you or would you have any problems chewing gum?

- ◯ yes
- ◯ no

Do you or would you have any problems chewing bagels or other hard foods?

- ◯ yes
- ◯ no

Have your teeth changed in the last 5 years, become shorter, thinner or worn?

- ◯ yes
- ◯ no

Are your teeth crowding or developing spaces?

- ◯ yes
- ◯ no

◯ yes
◯ no

Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?

◯ yes
◯ no

Do you have any problems with sleep or wake up with an awareness of your teeth?

◯ yes
◯ no

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)

◯ yes
◯ no

Have you been disappointed with the appearance of previous dental work

◯ yes
◯ no

Do you have tension headaches or sore teeth?

◯ yes
◯ no

Do you wear or have you ever worn a bite appliance?

◯ yes
◯ no

TOOTH STRUCTURE

Have you had any cavities within the past 3 years?

◯ yes
◯ no

Do you have dry mouth?

◯ yes
◯ no

Are any teeth sensitive to hot or cold, biting or sweets?

◯ yes
◯ no

Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?

◯ yes
◯ no

Do you avoid brushing any part of your mouth?

- ◯ yes
- ◯ no

Do you feel or notice any holes (i.e. pitting) in your teeth?

- ◯ yes
- ◯ no

GUM AND BONE

Have you ever been diagnosed or treated for periodontal (gum) disease?

- ◯ yes
- ◯ no

Have you ever experienced gum recession?

- ◯ yes
- ◯ no

Is there anyone with a history of periodontal disease in your family?

- ◯ yes
- ◯ no

Do your gums bleed when brushing flossing or eating?

- ◯ yes
- ◯ no

Are your teeth becoming loose?

- ◯ yes
- ◯ no

Have you ever noticed an unpleasant taste or odour in your mouth?

- ◯ yes
- ◯ no

Have you experienced a burning sensation in your mouth?

- ◯ yes
- ◯ no

Patient's Signature: _____ _____

Doctor's Signature: _____ _____

ELECTRONIC COMMUNICATION CONSENT - Dr. John Bjornson, Inc.

Dr. John Bjornson, Inc.

Email communication provides for a fast and easy way to communicate with your dental care team for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-dental care provider/team relationship; rather it can support and strengthen an already established relationship.
The following summarizes the information you need to determine whether you wish to supplement your dental care experience at our practice by electronically communicating with team members of Dr. John Bjornson, Inc.

General Considerations
Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.

Standard email communication services, such as AOL, Yahoo and Hot Mail are not secure. This means that the email messages are not encrypted and can be potentially Intercepted and read by unauthorized individuals.

Your email address will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice, however, the recipients email addresses will be hidden.

Dental Care Team Responsibilities
Team will attempt to electronically confirm your email address by requesting a return response to all email messages.

Various team members may receive and read your email.

Every attempt will be made to respond to your email message within 2 business days (Monday - Friday, non-holidays). If you do not receive a response from the practice within 2 business days please contact the practice by phone.

Copies of emails sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities
Email messages should not be used for emergencies or time sensitive situations. In the event of a dental emergency you should contact the practice by phone.

Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.

I have read the information above and agree to submit the form electronically

◯ I agree