

Demographics

Date (dd/mm/yyyy): _____

 Name: (First) _____ (M.I) _____ (Last) _____ Male Female Non-Binary

Care Card: _____ Family Physician: _____ Fax: _____

Address: _____ (Apt) _____ City: _____

Postal Code: _____ Cell Phone: _____ Home Phone: _____

 Email: _____ Marital Status: Single / Married / Other

Height: _____ Weight: _____ Age: _____ Birthday: (dd/mm/yyyy) _____

BMI: _____ *calculated upon arrival

Emergency Contact

Name (First) _____ (Last) _____ Tel: _____

Relationship to patient: _____ City: _____

 Same household as patient? Yes No
Employment Information

 Full-time Part Time Student Retired Other

Occupation: _____

Employer/School: _____ City: _____

Referral Information

Referred by (Patient, Physician or Dentist): _____

How did you hear about Timberlea Services Centre? _____

 Facebook

 Electric Billboard

 Mommy Network

 Instagram

 Street Signage

 Trade Show

 Email

 Radio Ad

 Movie Theatre Ad

 Word of Mouth

 Have you been to our dental website <https://timberleasc.ca/> ? Yes No

 If yes, did you find it helpful? Yes No / If No please explain: _____

Procedure Information

What procedures are you interested in or referred for? (Check all applicable procedures below)

Non-Surgical	Surgical Procedures	Restorative Dentistry with Sedation
<input type="checkbox"/> Botox for TMJ <input type="checkbox"/> Consultation only	<input type="checkbox"/> Wisdom teeth extractions <input type="checkbox"/> Bone Grafting <input type="checkbox"/> Sinus Lift <input type="checkbox"/> Dental Implant <input type="checkbox"/> Biopsy <input type="checkbox"/> Tongue concerns <input type="checkbox"/> Jaw concerns	<input type="checkbox"/> Routine Dental Cleaning <input type="checkbox"/> Root Canal <input type="checkbox"/> Fillings <input type="checkbox"/> Other: _____ _____

Please describe why you are interested in the above procedure(s):

Have you consulted with other physicians about the above procedure(s) before? Yes No

If yes, please indicate: Dr. (Name): _____ City: _____ Year: _____

Surgery Scheduling

To help us better understand your individual needs and time preference for your surgery, please provide us with the following:

If you choose to have surgery what month(s) would work best for you? _____

Personal Health Information

Do you have, or have you had, any of the following? Check (v) yes if applicable:

- | | | |
|---|---|--|
| <input type="checkbox"/> Acrylic Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Amoxicillin Allergy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Local Anesthetics Allergy |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Fainting Spells/ Dizziness | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Metal Allergy |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Taking Birth Control |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Clindamycin Allergy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cortisone Medication Allergy | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Yellow Jaundice |

Other not listed:

Family History

Do you have a family history of any medical problems?

Please indicate family members: _____

Review of Systems

Please answer the following yes or no questions to the best of your ability. Please provide details to conditions you checked "yes"

Anesthesia			
Malignant hyperthermia of life threatening reaction to anesthesia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:
Blood relative with life threatening reaction to anesthetic?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:
Problems during past procedures involving anesthesia (including dental)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Difficulty with breathing tube insertion <input type="checkbox"/> Persistent nausea/vomiting <input type="checkbox"/> Slow awakening after anesthesia <input type="checkbox"/> Long lasting confusion and disorientation <input type="checkbox"/> Poor reaction to local anesthesia or freezing <input type="checkbox"/> Other: _____
Problems with swallowing, chewing, or dental issues/disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Dentures (Full <input type="checkbox"/> or Partial <input type="checkbox"/>) <input type="checkbox"/> Tongue piercing <input type="checkbox"/> Missing, loose or capped teeth <input type="checkbox"/> Temporary Mandibular Joint (TMJ) Disorder <input type="checkbox"/> Difficulty opening mouth or extending neck
Sleep Apnea			
Diagnosis of Sleep Apnea or the use of a CPAP Machine (breathing device)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Use of CPAP
If you answered NO to the above please complete ->	STOP BANG Questionnaire		
	1. Do you snore loudly? (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	2. Do you often feel tired, fatigued or sleepy during the daytime (such as falling asleep talking to someone?) Yes <input type="checkbox"/> No <input type="checkbox"/>		
	3. Has anyone observed you stop breathing or choking/gasping during your sleep? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	4. Do you have, or are you being treated for High Blood Pressure? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	5. Is your BMI >35 kg/m2 Yes <input type="checkbox"/> No <input type="checkbox"/>		
	6. Are you older than age 50? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	7. Neck size large ? (Measured around Adams apple) For male, is your shirt collar 17 inches / 43cm or larger?		

		<p>For female, is your shirt collar 16 inches / 41cm or larger? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>8. Are you male gender? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>STOP-BANG SCORE</p> <p><input type="checkbox"/> Yes to 0-2 questions = low risk <input type="checkbox"/> Yes to 3-5 questions = intermediate risk <input type="checkbox"/> Yes to >5 questions = high risk</p>			
Allergies and Reactions			
Allergy to medications?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please explain: _____ _____
Allergic to latex (including dental dams, gloves and condoms)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Last reaction: _____ _____
Other allergies or allergic-like reactions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please list and describe reactions: _____ _____
Respiratory			
Have you been diagnosed with any breathing or respiratory problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Difficulty with breathing at rest <input type="checkbox"/> Mild asthma (no medications) <input type="checkbox"/> Asthma (controlled with medications) <input type="checkbox"/> Chronic asthma (no medication) <input type="checkbox"/> COPD- including emphysema or chronic bronchitis <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Pulmonary Fibrosis <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Pneumonia within the last month <input type="checkbox"/> Home Oxygen _____ litres/min <input type="checkbox"/> Other: _____
Function			
Difficulty with exercise/everyday movements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Shortness of breath: <input type="checkbox"/> At rest <input type="checkbox"/> During exercise <input type="checkbox"/> Climbing stairs <input type="checkbox"/> Use of cane or walker <input type="checkbox"/> Use of wheelchair <input type="checkbox"/> Muscular pain <input type="checkbox"/> Joint pain, including arthritic pain <input type="checkbox"/> Other: _____
Cardiovascular			
High blood pressure or take blood pressure medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> High blood pressure – not using medication <input type="checkbox"/> High blood pressure- somewhat controlled with medication <input type="checkbox"/> Normal blood pressure- controlled with medication
Heart trouble/issues?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Heart attack- When: _____ <input type="checkbox"/> Chest pain or angina – with exercise <input type="checkbox"/> at rest <input type="checkbox"/> <input type="checkbox"/> Chest pressure <input type="checkbox"/> Congestive heart failure (including fluid in lungs) <input type="checkbox"/> Heart valve problems or murmur <input type="checkbox"/> Irregular heartbeat or palpitations <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Peripheral vascular disease



			<input type="checkbox"/> Hypotension (low blood pressure) <input type="checkbox"/> Blood clot in lungs or legs (including deep vein thrombosis – DVT) <input type="checkbox"/> Other: _____
Implanted heart device (pacemaker or ICD)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Implanted Cardioverter Defibrillator <input type="checkbox"/> Pacemaker- last checked (date) _____ Are you always dependent on your pacemaker? Yes <input type="checkbox"/> No <input type="checkbox"/>
Open heart surgery, heart valve or blood vessel surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Any type of clotting disorder or disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Sickle cell disease or hemochromatosis <input type="checkbox"/> Hemophilia <input type="checkbox"/> Anemia <input type="checkbox"/> Blood clots <input type="checkbox"/> Phlebitis <input type="checkbox"/> Von Willebrand's Disease
Diabetes			
Any Type of Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 – taking insulin <input type="checkbox"/> Type 2- taking pill medications <input type="checkbox"/> Type 2- not taking medications
Endocrine			
Any type of kidney disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney stones
Any type of thyroid disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Low thyroid (Hypothyroidism) <input type="checkbox"/> High thyroid (Hyperthyroidism)
Any type of liver disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Cirrhosis Caused by: <input type="checkbox"/> Hepatitis <input type="checkbox"/> Alcohol/Drugs Other: _____
Neurological			
Any type of neurological disorder or impairment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Seizures or epilepsy. Date of last seizure: _____ <input type="checkbox"/> Brain tumor, aneurysm, or other vascular lesion of the brain <input type="checkbox"/> Concussion or brain injury <input type="checkbox"/> Dementia or Alzheimer's <input type="checkbox"/> Neurostimulator <input type="checkbox"/> Confusion <input type="checkbox"/> Stroke, Mini-stroke (TIA) <input type="checkbox"/> Full recovery <input type="checkbox"/> Partial recovery
Any type of neuromuscular disorder or impairment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> ALS/Lou Gehrig's disease <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Paralysis
Any risk of CJD (Creutzfeld-Jacobs Disease, sometimes known as "Mad Cow")?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Suspected CJD <input type="checkbox"/> Family history of CJD or other prion disease <input type="checkbox"/> Growth hormone or gonadotrophin treatment from human pituitary glands (Year of treatment: _____) <input type="checkbox"/> Surgery on brain or spinal cord

Musculoskeletal			
Any type of muscular/skeletal disease or injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Recent fractures <input type="checkbox"/> Joint replacement <input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Back pain, neck pain or deformity that limits movement Details: _____
Gastrointestinal			
Any type of gastrointestinal issues or disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Hiatus hernia <input type="checkbox"/> Chronic heart burn or acid reflux <input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Irritable Bowel Syndrome (IBS) <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Other: _____
Mental Health			
Have you been diagnosed with a mental health concern?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood disorder <input type="checkbox"/> Currently medicated <input type="checkbox"/> Recent admission to hospital <input type="checkbox"/> Previous suicide attempts
Infections			
Any type of chronic infections?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> HIV <input type="checkbox"/> Other STDs (Describe: _____) <input type="checkbox"/> Hepatitis <input type="checkbox"/> Other: _____
At risk for antibiotic resistant infection?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Confirmed antibiotic resistant organism (ARO) such as MRSA, VRE, or C-difficile? Location: _____ <input type="checkbox"/> Has anyone in your household been diagnosed with an ARO such as MRSA/VRE? <input type="checkbox"/> Have you received healthcare in a facility outside of Canada within the last 12 months? <input type="checkbox"/> Have you been admitted to, or spent more than 12 hours continuous as an inpatient in any healthcare facility in the last 12 months?
Lifestyle, Current Health and Substance Use Screening			
Do you smoke (or did you), consume alcohol, or use recreational drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Current smoker, _____ cigarettes/day <input type="checkbox"/> Past smoker _____ years ago <input type="checkbox"/> Consume alcohol _____ drinks/week <input type="checkbox"/> Recreational drugs (type): _____ _____ <input type="checkbox"/> Nicotine product use (patch, inhaler, gum) <input type="checkbox"/> Vaping



Pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many weeks? _____
Current illness or injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Cold or flu <input type="checkbox"/> Injury _____ <input type="checkbox"/> Infection: _____ <input type="checkbox"/> Open wound or abscess <input type="checkbox"/> Acute temporary pain (less than 6 weeks) <input type="checkbox"/> Mild temporary pain (less than 6 weeks) <input type="checkbox"/> Chronic pain (more than 6 weeks) <input type="checkbox"/> Other: _____
Being treated for cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Type _____ <input type="checkbox"/> Chemotherapy in the last 90 days <input type="checkbox"/> Radiation in the last 90 days <input type="checkbox"/> In remission _____ (number in years)
Significant weight loss or weight gain within the last 6 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Weight gain _____ (lbs) <input type="checkbox"/> Weight loss _____ (lbs) <input type="checkbox"/> Weight loss surgery Type: _____ When: _____
Past Surgeries (list below)			
Check if none <input type="checkbox"/>			
Procedure:	Facility: _____ Date: _____		
Procedure:	Facility: _____ Date: _____		
Procedure:	Facility: _____ Date: _____		
Medications (including over the counter, vitamins, supplements and herbal remedies)			
Check if none <input type="checkbox"/>			
include dose, and how often you take the medication			
Drug Name:	Dose:	Reason:	
Drug Name:	Dose:	Reason:	
Drug Name:	Dose:	Reason:	
Drug Name:	Dose:	Reason:	

Thank you for providing us with this important information!

Form completed by:

Name (printed):

Signature: _____ Date: _____