ANDREA STEVENS DENTISTRY

120-350 Palladium Drive
Kanata, ON K2V 1A8
P: 613.271.7091
info@drandreastevens.com

Please fully complete and return this form at least 2 business days prior to your visit as Dr. Stevens would like the opportunity to review your medical records.

Personal Information	Contact Information
Title: _____	
First Name: _____	Home: _____
Last Name:_____	Work: _____
Gender: _____	Cell: _____
Date of Birth: _____ / _____ / _____	Other: _____
Street/Mailing address: _____	
_____	Email: _____
City: _____	
Province: _____	Preferred contact option: _____
Postal Code: _____	
Occupation: _____	
Medical Doctor Name: _____	
Medical Doctor Address: _____	
_____	
Medical Doctor Phone Number: _____	

Please describe the reason for your visit _____
_____

Are you taking any medications, non-prescription vitamins or herbal supplements? Please list all (attach list if more than 4 medications).

Medication	Quantity	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your doctor ever indicated that you require an antibiotic before dental therapy? YES NO
If yes, please list for what reason: _____

Do you smoke or chew tobacco products? YES NO If YES, how much/many per day? _____

WOMEN: Are you pregnant or breast feeding? _____ IF PREGNANT: Expected date of delivery _____

There is now a well-known link between gum disease and several significant medical conditions. Please indicate any of the below that you have a family history of:

Heart Disease	Stroke	Diabetes	Obesity	Cancer
Periodontal Disease	Osteoporosis	Alzheimers	Gastric or Peptic Ulcers	

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Do you have or have you ever had any of the following? Please check all that apply.

SHORTNESS OF BREATH	TUBERCULOSIS	CANCER, type:
STEROID THERAPY	STOMACH ULCERS/GASTRIC REFLUX	LATEX SENSITIVITY
ARTHRITIS, where:	THYROID	DRUG OR ALCOHOL DEPENDANCY
AIDS/HIV	ALLERGIES to:	REACTION TO MEDICATIONS, type:
CONGENITAL HEART DISEASE	HEART MURMER	HEART ATTACK OR CONDITION OR SURGERY
HIGH BLOOD PRESSURE	MITRAL VALVE PROLAPSE	ARTIFICIAL JOINTS, where:
KIDNEY TROUBLES	RADIATION OR CHEMOTHERAPY	EPILEPSY OR SEIZURES
DIABETES, type:	HEPATITIS, type:	SICKLE CELL DISEASE
NEUROLOGICAL DISORDERS	HEADACHES (how often, what type) _____	STROKE
PACEMAKER	ARTIFICIAL HEART VALVE	ASTHMA
SLEEP APNEA (CPAP?)	HEAD/NECK/FACE INJURY? WHEN? _____	

Please list and explain any disease, condition or problem not listed:

_____

The National Highway Transportation Safety Administration estimates that over 100,000 crashes each year are caused by sleepy drivers. An estimated 50,000+ premature and preventable deaths may occur each year as a consequence of UNTREATED Obstructive Sleep Apnea. The most common terminal events are stroke, heart attack and accidents. Please answer the following questions by selecting the appropriate response to each situation, and we will calculate the results below.

How likely are you to doze off or fall asleep in the following situations (in contrast to just feeling tired)? Please score between 0 for "not at all" to 3 for "extremely likely":

1. While sitting and reading… _____
2. Watching television… _____
3. Sitting, inactive in a public place… _____
4. As a passenger in a car for an hour without a break… _____
5. Lying down to rest in the afternoon… _____
6. Sitting a talking with someone… _____
7. Sitting quietly after lunch without alcohol… _____
8. In a car, while stopped at a traffic light… _____

TOTAL (range 0-24) _____

Please describe your normal home care for your teeth and gums.

_____

_____

Is there any information pertaining to your past dental or medical experiences that you feel we should know about that would better help us to individualize your care?

_____

_____

_____

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In order for us to be sensitive to your needs, please tell us of any unpleasant experiences you may have had related to oral care.

_____

_____

_____

Dental Insurance:
Please note that the team at Dr. Andrea Stevens Dentistry will be more than happy to electronically submit your treatment to your insurance at time of payment. Payment is due at time of appointment. We have the ability to electronically submit to the primary insurance only, should there be secondary insurance you will be provided with a printed claim form which you will have to submit with the response from the primary insurance.

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Carrier:	Insurance Carrier:
Policy Number:	Policy Number:
Subscriber ID:	Subscriber ID:
Subscriber Name: Date of Birth:	Subscriber Name: Date of Birth:
Employer:	Employer:

Your electronic signature will verify that the information entered on these forms is correct to the best of your knowledge. This will also authorize Dr. Stevens and her team to contact your health care provider(s) or other dental specialists concerning your oral health and recommended treatment if necessary.

_____ _____

Signature of Patient Date

_____

Signature of Parent (if patient is a minor)