**Welcome to** **Kelowna Oral Medicine and TMJ Clinic**

**We are pleased you have chosen us.**

Please help us ensure we have all the correct information on file for you to best serve your needs.

ACCOUNT INFORMATION:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays date (day/month/year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth (day/month/year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Health #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (H): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C): \_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_

Gender: Male / Female / Other Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_ Spouse name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION (if applicable):

DENTAL INSURANCE #1:

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holders date of birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL INSURANCE #2:

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holders date of birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL QUESTIONS:

Are any areas in your mouth hurting you? Yes or No If yes, please specify:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a specific concern you want Dr. Tareq Aldajani to address first? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What are the symptoms you are experiencing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this been a problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*If you are a new patient -* How long has it been since your last dental visit? \_\_\_\_\_\_\_\_\_ last **hygiene** visit? \_\_\_\_\_\_\_\_\_\_\_\_

Have you had any health problems in the past five (5) years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a physician or other health care provider in the past two (2) years? Yes or No

Family Doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # or city: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you ever had any surgery? Yes or No If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a physician’s care for a specific ailment? Yes or No If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been advised to take antibiotics before a dental appointment due to a health condition? Yes or No

Any other condition that you think we should be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list **ALL** Medications/multi-vitamins and supplements you are currently taking (and note what condition you are taking them for)

Medication: Reason for use: Medication: Reason for use:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. |   | 6. |   |
| 2. |   | 7. |   |
| 3. |   | 8. |   |
| 4. |   | 9. |   |
| 5. |   | 10. |   |

**PLEASE CIRCLE OR CHECK ALL THAT APPLY:**

**HEART/BLOOD/JOINTS**  **None □**

□ Artificial heart valve

□ History of endocarditis

□ Congenital heart disease/Rheumatic fever

□ Heart transplant or a problem with a heart valve

□ Joint replacement

High Blood Pressure/Heart Attack /Pacemaker/Chest pain/Stroke/irregular/rapid heartbeat/stent placement

Other heart or vessel disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood clots or thrombosis/Anemia/Sickle cell

disease or trait/Hemophilia/Transfusion/Hepatitis: \_\_

Other blood disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NERVES None □**

Epilepsy/Seizures/MS/Trigeminal Neuralgia/

Chronic pain/Anxiety/Depression/Autism/ADHD/

Psychiatric treatment or counseling

Other nerve disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEAD & NECK** **None □**

Frequent or severe nosebleeds/Acid reflux

difficulty swallowing/Glaucoma/Headaches/

Sinusitis/ Injuries to head, neck, jaw, teeth: Date: \_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ENDOCRINE** **None □** Low thyroid/Cushing’s syndrome/

Parathyroid condition/ Diabetes (Type 1 or Type 2)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MUSCLES/BONES** **None □**

Sjogren’s Syndrome/Arthritis/Cerebral Palsy/

Chronic back pain/

other bone or muscle disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**URINARY TRACT None □** Kidney Disease/ Renal Dialysis/ STD

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BREATHING**  **None □**

TB/ Asthma/ Bronchitis/ Emphysema/

Persistent Cough/Shortness of Breath

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CANCER** **None □**

Leukemia/benign tumors/growths

Type/location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Types of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES** **None □**

Have you ever had an allergic reaction or bad reaction to any of the following?

Dental anesthetics/Penicillin/Sulfa drugs/ antibiotics/Aspirin/Latex/ Metals

 Other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** **None □**

Has anyone in your family ever had:

Diabetes/Heart Disease/TB/Depression

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MISC.**  **None □** HIV/Organ transplant/Lupus/

Methamphetamine/IV drugs/

Tobacco usage/Alcoholism

**GENETIC/OTHER None □**

Downs Syndrome/Cystic Fibrosis/

Sickle Cell/ Huntington’s/Parkinson’s

**WOMEN:** Are you pregnant? YES or NO OR Taking birth control pills? YES or NO

**MRONJ Risk Assessment Survey**

1. Are you currently taking or have you taken any bisphosphonates (e.g., Alendronate, Zoledronic acid) or other medications for osteoporosis or cancer treatment?
	* Yes / No
2. Have you received treatment with RANKL inhibitors (e.g., Denosumab) for bone metastasis or osteoporosis?
	* Yes / No
3. Are you undergoing or have you undergone chemotherapy or radiation therapy for cancer?
	* Yes / No
4. Have you experienced recent dental extractions or invasive dental surgeries in the past year?
	* Yes / No
5. Do you have a history of steroid use for any medical condition (e.g., Prednisone)?
	* Yes / No
6. Are you currently experiencing pain, swelling, or exposed bone in your mouth or jaw?
	* Yes / No
7. Are you a smoker or do you have a history of smoking?
	* Yes / No
8. Do you have any known conditions affecting bone metabolism (e.g., osteoporosis, Paget’s disease)?
	* Yes / No

**The fees for your appointment will be charged accordingly. You will be responsible for treatment payment. If you have dental insurance, we are happy to check coverage and submit all claims on your behalf for preauthorization. This means you will pay our office directly. We will submit all claims and information to your provider, and you will receive the reimbursement directly. Unfortunately, we are not responsible for any disturbance in payment or delayed payments through your insurance company.**

Do you give consent to Kelowna Oral Medicine and TMJ Clinic to share your health records with your other medical professionals on your behalf?

YES or NO

Do you consent to Kelowna Oral Medicine and TMJ Clinic and Dr. Tareq Aldajani utilizing your radiographs, photographs, medical history, and disease-related information for research or educational purposes? Please note that no personal or sensitive information will be disclosed in this process.

YES or NO

Signature/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_