Reflections
DENTAL GROUP

Welcome to Reflections Dental Group! We are happy you landed here and are excited to work with you to create the best treatment plan possible. You can help us by completing this form in as much detail as possible so we can meet your individual needs. I know, forms aren't my favourite thing to do either 😕but I promise it will pay off in the long run.

In the meantime, please let us know if you have any questions or concerns.

Yours in health,

Dr. Ashish Mehta

YOUR CONTACT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Postal Code _____

Email _____

Phone Number _____ _____ _____

EMERGENCY CONTACT INFORMATION

Name of contact _____

Phone _____

Email _____

Relationship _____

ABOUT YOU

The better we understand you, the better we can serve you. In keeping with our principles and promises, we believe you are the expert on yourself. Please indicate your preferences or opinions below by choosing a ranking from Lkow - High .

CURRENT STATE OF DENTAL HEALTH

INSTRUCTIONS

Place a checkmark on the following scale as each statement pertains to your dental health.

	LOW		AVERAGE		HIGH
I believe my current state of dental health is poor.	○	○	○	○	○	I believe my current state of dental health is excellent.
I consider my dental health a minimal priority.	○	○	○	○	○	I consider my dental health a high priority.
I am indifferent about keeping my teeth.	○	○	○	○	○	I will do whatever I must to keep my teeth.
I am satisfied with my smile.	○	○	○	○	○	I wish my smile was better.
I prefer short term solutions at a lower cost.	○	○	○	○	○	I prefer long lasting solutions that may cost more.
My insurance will dictate the extent of my care.	○	○	○	○	○	I will determine the extent of my care.

When was your last cleaning? YR/Month

When was your last oral cancer screening? YR/Month

When was your last set of xrays? YR/Month

If I could change my smile, I would...

- [ ] Make my teeth brighter
- [ ] Make my teeth straighter
- [ ] Close the spaces
- [ ] Replace black metal fillings with tooth-coloured fillings
- [ ] Repair chipped teeth
- [ ] Replace missing teeth
- [ ] Replace old crowns that don't match

Please indicate which of the following apply to you

- [ ] Sensitivity to cold
- [ ] Pain/discomfort when chewing
- [ ] Headaches, earaches, neck pain
- [ ] Jaw Joint Pain (TMJ)
- [ ] Teeth or fillings breaking
- [ ] Grinding or clenching teeth
- [ ] Bleeding, swollen or irritated gums
- [ ] Loose or shifting teeth
- [ ] Bad breath or taste in your mouth
- [ ] Problems sleeping or snoring

What do you value most in your dental visits (please choose 3)

- [ ] Quality
- [ ] Punctuality
- [ ] Time spent to explain
- [ ] Treatment
- [ ] Efficiency
- [ ] Comfort
- [ ] Office Ambiance
- [ ] Current Technology
- [ ] Checking insurance coverage
- [ ] Other

MEDICAL HISTORY (BOLDED conditions are linked to periodontal disease)

Please check all which apply to you

- Acid Reflux
- AIDS
- Addiction
- Allergies
- Anemia
- **Arthritis**
- Artifical joints
- Artifical Valves
- Asthma
- Blood Disorders
- **Cancer**
- Chemotherapy
- **Dementia**
- **Diabetes**
- Dizziness
- Emphysema
- Epilepsy
- Excessive Bleeding
- Fainting
- Glaucoma
- **Heart Attack**
- Heart surgery
- Hepatitis A/B/C
- HIGH Blood Pressure
- HIV
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- **Osteoporosis**
- Pacemaker
- Radiotion Therapy
- **Pregnant**
- **Respiratory Problems**
- Sleep Apnea
- **Stroke**
- Surgery
- Thyroid Disease
- Tuberculosis
- Tobacco Use (Vape, Chew, Smoke)
- Other

DO YOU HAVE ANY OF THE FOLLOWING ALLERGIES ?

- I don't have any allergies
- Local Anesthetic
- Codeine
- Acetaminophen (Tylenol)
- Ibuprofen (Advil)
- Antiobiotics
- Sulfa Drugs
- Latex
- Lactose
- Food Allergy
- Seasonal Allergy
- Other

DO YOU TAKE ANY MEDICATION ?

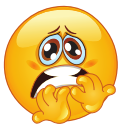
MEDICATION NAME	DOSAGE AND REASON

Are you under the care of a physician ?

YES NO

DENTAL ANXIETY

How do you feel about going to the dentist? (check one)





Comfort

Is there anything you prefer during your visits to make you more comfortable?
(blanket, pillow, noise-cancelling headphones, hearing dad jokes...already included in all visits.)

Finally, please share with us how we can make your dental visit a positive one.

INSURANCE INFORMATION

Insurance Company	Group #	ID #
Seconday	Group #	ID #
Policy Holder	Employer	Birthday

PATIENT (Parent/Guardian) Signature: _____ Today's Date _____