Dentistry By DR. GENOVEVA CAMINSCHI

p 905.804.8182 | f 905.804.8183 | info@drcaminschi.com
918 Dundas St. East, Mississauga, ON L4Y 4H9

Medical & Dental History

Name: ______________________________ Date: ______________________

Sex: ______________ Birthdate: __________________ Age: ____________

Address: ____

City: ________________ Province:______________ Postal Code: ___________

Home #: ______________ Cell #: ______________ Work #: _______________

Please indicate phone # you prefer we contact you at? _____________________

Marital Status (please circle one): single☐ married☐ widowed☐ separated☐ divorced☐

***If married** (for emergency purposes only):*

Spouse's name:______________________________

Phone # we can contact your spouse at: _________________________

Medical History

Your answers are for our record only and will be considered confidential.
Please answer them to the best of you knowledge. These facts have a direct bearing on your dental health.

Name of Physician: ____________________________ Doctor's office #: ________________________________

Date of last physical exam: ______________________________

Please circle 'yes' or 'no', whichever applies, for the following questions.

1. Are you in general good health?.. ☐Yes No☐
2. Has there been any changes in your general health within the last year?...................... ☐Yes No☐
3. Are you now under a physician's care?.. ☐Yes No☐
   If yes, for what condition? ____
4. Have you had any serious illness or operation?... ☐Yes No☐
   If yes, please list: ____
5. Have you been hospitalized or had a serious illness within the past 5 years?.............. ☐Yes No☐
   If yes, what reason? ____

Cardiovascular system

1. Do you have or have you ever had any of the following:

Heart trouble Heart attack Stroke
Damaged heart valves Congenital heart disease
Coronary insufficiency None

2. Rheumatic heart disease or heart murmur?.......... ☐Yes No☐

3. Chest pain after exertion?...................................... ☐Yes No☐

4. Do you have a cardiac pacemaker?.......................... ☐Yes No☐

5. Do you have any blood pressure problems?........... ☐Yes No☐

High __________ Low __________

Respiratory System

1. Do you have or have you ever had Tuberculosis?... ☐Yes No☐

2. Is there any history of Tuberculosis in your family?... ☐Yes No☐

3. Do you have any sinusitis or sinus trouble?... ☐Yes No☐

4. Do you have Emphysema, Chronic Bronchitis or Asthma?...................... ☐Yes No☐

hematopoietic system

1. Do you have Anaemia, Sickle cell disease or any blood disorders?....................................... ☐Yes No☐

2. Are you haemophilic?... ☐Yes No☐

3. Have you had abnormal bleeding after surgery, extraction, or trauma?...................... ☐Yes No☐

4. Have you ever had a blood transfusion?...... ☐Yes No☐

Genitourinary system

1. Do you have or have you ever had kidney trouble?... ☐Yes No☐

2. Have you been exposed to the HIV virus?....... ☐Yes No☐

3. Do you have AIDS?.. ☐Yes No☐

Central Nervous system

1. Do you have or have you ever had:

a. epilepsy..................................... ☐Yes No☐
b. fainting spells............................ ☐Yes No☐
c. seizures..................................... ☐Yes No☐
d. emotional disturbances............. ☐Yes No☐

2. Do you follow any treatment for a nervous disease?

☐Yes No☐

Digestive system

1. Do you have any stomach ulcers? .... ☐Yes No☐

2. Do you have or have you ever had:

a. hepatitis....................................... ☐Yes No☐
b. jaundice....................................... ☐Yes No☐
c. liver disease................................. ☐Yes No☐

endocrine system

1. Do you have Diabetes?.. ☐Yes No☐

2. Do you have hypothyroidism?.............................. ☐Yes No☐

3. Do you have hyperthyroidism?............................ ☐Yes No☐

Allergies

1. Are you allergic to or have you acted adversely to:

a. Local anaesthetics................................. ☐Yes No☐
b. Antibiotics, Penicillin, or Sulpha drugs... ☐Yes No☐
c. Barbiturates, sedatives, or sleeping pills. ☐Yes No☐
d. Aspirin... ☐Yes No☐
e. Codeine or other narcotics....................... ☐Yes No☐
f. Other.. ☐Yes No☐

2. Do you have Asthma or Hay Fever?.................... ☐Yes No☐

3. Do you have or have you ever had hives or a skin rash?... ☐Yes No☐

If you have answered yes to any of the allergy questions, please provide more information:

____

____

Bone & joints

1. Do you have:

- *a. Arthritis*..☐Yes No☐
- *b. Inflammatory Rheumatism*..............☐Yes No☐
- *c. Bone Infection*...................................☐Yes No☐
- *d. Osteoporosis*.......................................☐Yes No☐

Miscellaneous

1. Are you wearing, or do you wear contact lenses?..☐Yes No☐

2. Do you drink alcohol?...☐Yes No☐
If yes, how much and how often? ____________________

3. Do you smoke or use tobacco?..........................☐Yes No☐
If yes, how much and how often? ____________________

women

1. Are you pregnant?...☐Yes No☐

2. Are you nursing?...☐Yes No☐

3. Are you taking oral contraceptives or hormonal therapy?..☐Yes No☐

neoplasms

1. Do you have or have you ever had:

- *a. Tumours or malignancies*.................☐Yes No☐
- *b. Chemotherapy or Radiation Therapy*☐Yes No☐

Medications

1. Are you taking any of the following medications?

- *a. Antibiotics or sulfa drugs*.................☐Yes No☐
- *b. Anticoagulants (blood thinners)*.....☐Yes No☐
- *c. Medicine for high blood pressure*....☐Yes No☐
- *d. Tranquilizers*.....................................☐Yes No☐
- *e. Codeine or other narcotics*...............☐Yes No☐
- *f. Other:*________________________________

If you are taking any medications, please give details of the name of the medications, the dose, frequency, and the reason for use:

____
____
____
____

Dental History

1. What is your chief complaint about your teeth?
   ____
   ____
2. How would you like us to help you?
   ____
   ____
3. Are you experiencing any discomfort or pain at this time?..................☐Yes No☐
4. Are you satisfied with the appearance of your teeth?.........................☐Yes No☐
5. Are you able to eat and chew foods satisfactorily?..............................☐Yes No☐
6. Do you have headaches, earaches, or neck pain?..................................☐Yes No☐
7. Do you have any problems with your jaw joints?...................................☐Yes No☐
8. Do you have any problems with your bite?...☐Yes No☐
9. Have you had serious trouble associated with previous dental treatment?..........☐Yes No☐
   If yes, please explain
   ____

Denture Patients

1. Do you wear partial or complete dentures?.... ☐ Yes No ☐
If yes, what do you have and when were they made?

____

2. Do your dentures move during function?......... ☐ Yes No ☐

3. Do your dentures hurt?.. ☐ Yes No ☐

4. Can you eat properly with your dentures?........ ☐ Yes No ☐

5. Do your dentures drop and cause social embarrassment?.. ☐ Yes No ☐

6. Are you satisfied with your facial appearance ☐ Yes No ☐

7. Are they satisfactory?.. ☐ Yes No ☐

Please expand on any problems and indicate any other denture concerns that you may have:

____

____

Additional Information

Is there anything in your medical and dental history that we have not specifically asked about that we should be aware of?... Yes No
If so, please explain

____

____

____

Consent

I, ________________________________ hereby authorize and request the performance of dental services for myself or for ________________________________.

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by Dr. Genoveva Caminschi and her supervised staff for diagnostic purposes or dental treatment.

The records may include study models, photographs and x-rays, which may be used for dental education and used in dental publications.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named regardless of insurance coverage.

I also understand that the treatment estimated presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee.

I believe the information given in the pages of this medical and dental history to be true to the best of my knowledge.

Signature of patient/guardian: ________________________________

Signature of Doctor: ________________________________

Date: ________________________________

Treatment Consent Form

What you are being asked to sign is a confirmation that we have discussed the nature and the purpose of dental treatment, the known risks associated with dental treatment, the feasible treatment alternatives, and that you have been given an opportunity to ask questions and all your questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand.

My signature on the bottom of this form certifies that:

1. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.
2. I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.
3. I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.
4. I understand that the estimate given to me is for normal and usual treatment. I understand that if my treatment requires extra time, additional procedures or laboratory work, there will be additional fees related to the additional time and treatment. Normal and usual treatment consists of 1 or 2 try-ins of the restoration and up to 5 post-insertion adjustments.
5. I understand that **Dr. Caminschi** has carefully examined my mouth. Alternatives to the chosen treatment have been explained. I have been informed and I understand the purpose and the nature of the dental procedure. I understand the procedures that are necessary to accomplish full completion of the dental treatment and fabrication of the prostheses.
6. I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia that include but are not limited to: root canal therapy, facture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.
7. I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need of extraction, fracture of teeth and/or roots, difficulties in chewing and/or speech. Also possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

8. My dentist has explained that there is no method to accurately predict the outcomes of dental treatment due to large variations in teeth, gums, bone, chewing forces, and oral hygiene. It has been explained to me that in some instances dental treatment may not be successful.
9. I agree to follow the home care instructions provided to me. I agree to report to my dentist for regular examinations as indicated and I understand that this office will monitor my progress unless I have been advised to return to my general dentist for dental care.
10. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anaesthetics, pollens, dust, any blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
11. I consent to photography, study models and X-rays of the procedure to be performed for use in teaching dentistry and other graphic purposes.
12. I understand that with any dental treatment, bacteria can damage my teeth, gums or bone and I must do my utmost to remove the bacterial plague off all the surfaces of all my teeth and/or implants every day. If I do not clean my teeth and/or implants properly, I may get decay and/or gum disease and my treatment may fail.

Implant Treatment Consent:

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand the procedure that is necessary to accomplish the placement of the implant under the gum or in the bone. I also understand that upon entering the surgical site, it may be determined that implant placement is not possible. If it is determined by my dentist that implants cannot be placed due to lack of bone, there will be a $350.00 fee to cover the cost of the time invested and the surgical set-up.
2. I understand that my dentist had carefully examined my mouth. Alternatives to implant therapy have been explained. I have tried or considered these methods, but I desire an implant to help secure the replacement restoration for my missing teeth.
3. I have been informed of the possible risks and complications involve with implant prosthetics that include but are not limited to the following: implant fracture, screw loosening or fracture, acrylic or porcelain fracture and cement failure.
4. **Dr. Caminschi** has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following tooth extraction or the placement of the implant. If there is inadequate bone or gum tissue, there may be a need for additional treatment. This is in the form of grafting procedures. These procedures can cost been $700.00 and $1200.00 per procedure. It has been explained to me that in some instances implants fail and must be removed.

5. I understand that excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant. I agree to follow the home care instructions provide to me. I agree to report to **Dr. Caminschi** for regular examinations as indicated.
6. I understand that a panorex, tomogram, and/or other X-rays will be taken before, during, and after treatment. A number of X-rays are required during the course of implant therapy and as every situation is different, it is impossible to estimate the cost of the radiographs. I understand that I will be charged for the radiographs in addition to my proposed treatment plan.
7. I understand that the implants used have full compliance under the regulations of Health and Welfare Canada, and I give **Dr. Caminschi** my permission to use whatever implants she feels are appropriate for my treatment.
8. I understand that I may not have sufficient bone for the placement of implants. I consent to the use of grafting materials in an attempt to create more bone. These materials include Demineralized Freeze-Dried Bone (a human bone product), hydroxylapatite, collagen and other artificial bone substitutes.

I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment.

I have also been fully informed of the nature of implants and implant surgery, therapeutic risks and prosthodontic treatment alternatives to oral implants and hereby consent to treatments.

Date　　Print Name　　Signature of Patient/Guardian

Date　　Print Name　　Signature of Doctor

Date　　Print Name　　Signature of Witness