CLEAR
DENTAL
PERIODONTICS AND PROSTHODONTICS

#103, 4222 Gateway Boulevard
Edmonton, AB T6J 7K1

P: 780.250.2728
F: 780.250.2729
E: info@clear-dental.ca

clear-dental.ca

DR. BEOM (MICHAEL) PARK
Certified Specialist in Periodontics and Prosthodontics

DR. CHIUNGYUN (KIRI) CHANG
Certified Specialist in Periodontics

Patient History

Patient's Name _____ Preferred Name: _____
First *Last* *M.I.*

Referred by: _____

Previous dentist: _____ For how long: _____

Date of most recent dental exam: _____

I have routinely seen my dentist every: ☐ 3-4 Months ☐ 6 months ☐ 12 months ☐ Not often

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your immediate concern? _____

Are you fearful of dental treatment? ☐ Yes ☐ No How fearful? (1-10): _____

Have you ever had an unfavorable dental experience? ☐ Yes ☐ No

Have you ever had complications from past dental treatment? ☐ Yes ☐ No

Have you ever had trouble getting numb or had any reactions to local anesthesia? ☐ Yes ☐ No

Did you ever have braces, orthodontic treatment, or have your bite adjusted? ☐ Yes ☐ No

If yes, at what age? _____

Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? ☐ Yes ☐ No

Gum and Bone

Please select all that apply to you:

- ☐ Bloody or painful gums when brushing or flossing
- ☐ Previous gum disease or bone loss around teeth
- ☐ Unpleasant taste or odor in mouth
- ☐ Family history of periodontal disease
- ☐ Gum recession
- ☐ Loose teeth (without any injury) or difficulty eating an apple
- ☐ Burning sensation or pain in mouth not related to teeth

Tooth Structure

Please select all that apply to you:

- ☐ Cavities within the past 3 years
- ☐ Amount of saliva seems to be too little or difficulty swallowing food
- ☐ Holes on the biting surface of teeth
- ☐ Teeth are sensitive to hot, cold, biting, sweets, or brushing
- ☐ Teeth have grooves/notches near gumline
- ☐ Broken teeth, chipped teeth, or cracked filling causing toothache
- ☐ Food often gets caught in between teeth

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Bite and Jaw Joint

Please select all that apply to you:

- ☐ You have problems with your jaw joint (pain, sounds, limited opening, locking, popping)
- ☐ You feel like your lower jaw has to push back when you bite your back teeth together
- ☐ You avoid or have difficulty chewing gum, carrots, nuts, bread, protein bars, or other hard, dry foods
- ☐ Your teeth have changed in the past 5 years (shorter, thinner, worn) or you bite has changed
- ☐ Your teeth are becoming more crooked, crowded, or overlapped
- ☐ Your teeth are developing spaces or becoming more loose
- ☐ You have trouble finding your bite or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together
- ☐ You place your tongue in between your teeth or close your teeth against your tongue
- ☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- ☐ You clench or grind your teeth together in daytime or make them sore
- ☐ You have problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache, or an awareness of your teeth
- ☐ You wear or have worn a bite appliance

Smile Characteristics

Please select all that apply to you:

- ☐ There is something about the appearance of your teeth you would like to change (shape, colour, size)
- ☐ You have whitened (bleached) your teeth
- ☐ You have felt uncomfortable or self-conscious about your teeth appearance
- ☐ You have been disappointed about the appearance of previous dental work

Medical History

Name of physician and their specialty: _____

Most recent physical examination and purpose: _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you ever had:

☐ Hospitalization for illness or injury? Reason: _____

An allergic or bad reaction to any of the following:

- ☐ Aspirin, Ibuprofen, Acetaminophen, Codeine
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Local Anesthetic
- ☐ Fluoride
- ☐ Metals (Nickel, Gold, Silver)
- ☐ Latex
- ☐ Nuts
- ☐ Fruit
- ☐ Other: _____

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Please select all of the following that you have or have ever had:

- ☐ Heart problems or cardiac stent within last 6 months
- ☐ History of infective endocarditis
- ☐ Artificial heart valve, repaired heart defect
- ☐ Pacemaker, implantable defibrillator
- ☐ Orthopedic implant (joint replacement)
- ☐ Rheumatic or scarlet fever
- ☐ High or low blood pressure
- ☐ A stroke (taking blood thinners)
- ☐ Anemia or other blood disorders
- ☐ Prolonged bleeding due to a slight cut (INR > 3.5)
- ☐ Pneumonia, emphysema, shortness of breath, sarcoidosis
- ☐ Tuberculosis, measles, or chicken pox
- ☐ Asthma
- ☐ Breathing or sleeping problems (i.e. sleep apnea, snoring, or sinus)
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Jaundice
- ☐ Thyroid, parathyroid disease, or calcium deficiency
- ☐ Hormone deficiency
- ☐ High cholesterol or taking statin drugs
- ☐ Diabetes (HbA1c)
- ☐ Stomach or duodenal ulcer
- ☐ Digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia)
- ☐ Osteoporosis or osteopenia (i.e. taking biphosphates)
- ☐ Arthritis
- ☐ Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)
- ☐ Glaucoma
- ☐ Contact lenses
- ☐ Head or neck injury
- ☐ Epilepsy or convulsions (seizures)
- ☐ Neurological disorders (ADD, ADHD, prion disease)
- ☐ Viral infections or cold sores
- ☐ Any lumps or swelling in the mouth
- ☐ Hives, skin rash, hay fever
- ☐ STI / STD / HPV
- ☐ Hepatitis ____
- ☐ HIV / AIDS
- ☐ Tumor or abnormal growth
- ☐ Radiation therapy
- ☐ Chemotherapy or immunosuppressive medication
- ☐ Emotional difficulties
- ☐ Psychiatric treatment
- ☐ Antidepressant medication
- ☐ Alcohol / recreational drug use

Please explain and date the above selected items: _____

_____

_____

_____

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Are You:

Please select all of the following that apply to you:

- ☐ Presently being treated for any other illness
- ☐ Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)
- ☐ Taking medication for weight management
- ☐ Taking dietary supplements
- ☐ Often exhausted or fatigued
- ☐ Experiencing frequent headaches
- ☐ A smoker, previously smoked, or use smokeless tobacco
- ☐ Often unhappy or depressed
- ☐ On a form of birth control
- ☐ Currently pregnant/breast-feeding
- ☐ Diagnosed with prostate cancer

Please explain and date the above selected items: _____

_____

_____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your treatment (i.e. Botox or Collagen injections): _____

_____

List all medications, supplements, and/or vitamins taken within the last two years:

Drug and purpose: _____

Drug and purpose: _____

Drug and purpose: _____

Drug and purpose: _____

Please advice the office in the future of any change(s) in your medical or dental history as well as medications you may be taking.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____