BURLINGTON PERIODONTICS
Reconstructive Periodontal & Implant Surgery
Suite 21 – 1960 Appleby Line, Burlington, ON. L7L 0B7
T: 289.337.1571 | F: 289.337.6326
info@burlingtonperiodontics.com
www.burlingtonperiodontics.com

**I would like to take this opportunity to welcome you to our practice**.
Please find some useful information regarding your upcoming appointment with us below:

On your first visit you will meet the team and I will complete a thorough assessment of the issue that your dentist has identified. We will be in contact with your dentist to obtain all the necessary notes and x-rays relevant to your periodontal care. If you have any further information or documents, please bring these with you to your consultation appointment.

The first visit will be a consultation where we will identify your concerns, determine a plan of action, and discuss any all questions you may have.
This typically takes about 40 minutes. Please arrive 5 minutes before your scheduled appointment to fill out some necessary paperwork, or you can fill it out ahead of time and bring it with you to our appointment. The paperwork is attached below.
Please bring a list of all the medications that you presently take to this appointment

Also, please let us know about your level of dental anxiety and anything we can do to make you more comfortable at our office.

Our regular office hours are Monday to Thursday 8:00 am to 5:00 pm

Our address: 1960 Appleby Line
Suite #21
Burlington, ON
L7L 0B7

Our phone number: (289) 337-1571

Our email: info@burlingtonperiodontics.com

The cost for this first visit is approximately $180 to $250.
Major credit cards are accepted. We can process insurance documents directly and submit estimates if you have your policy information available. Please bring this information with you to our appointment if you would like us to help you get reimbursed.

If you need to change this appointment, we ask that you give us 2 business days' notice so that we can accommodate someone else that may need that time for their treatment.

Thank you and we look forward to meeting you!

Sincerely,
Dr.Herman Thang and your team at Burlington Periodontics

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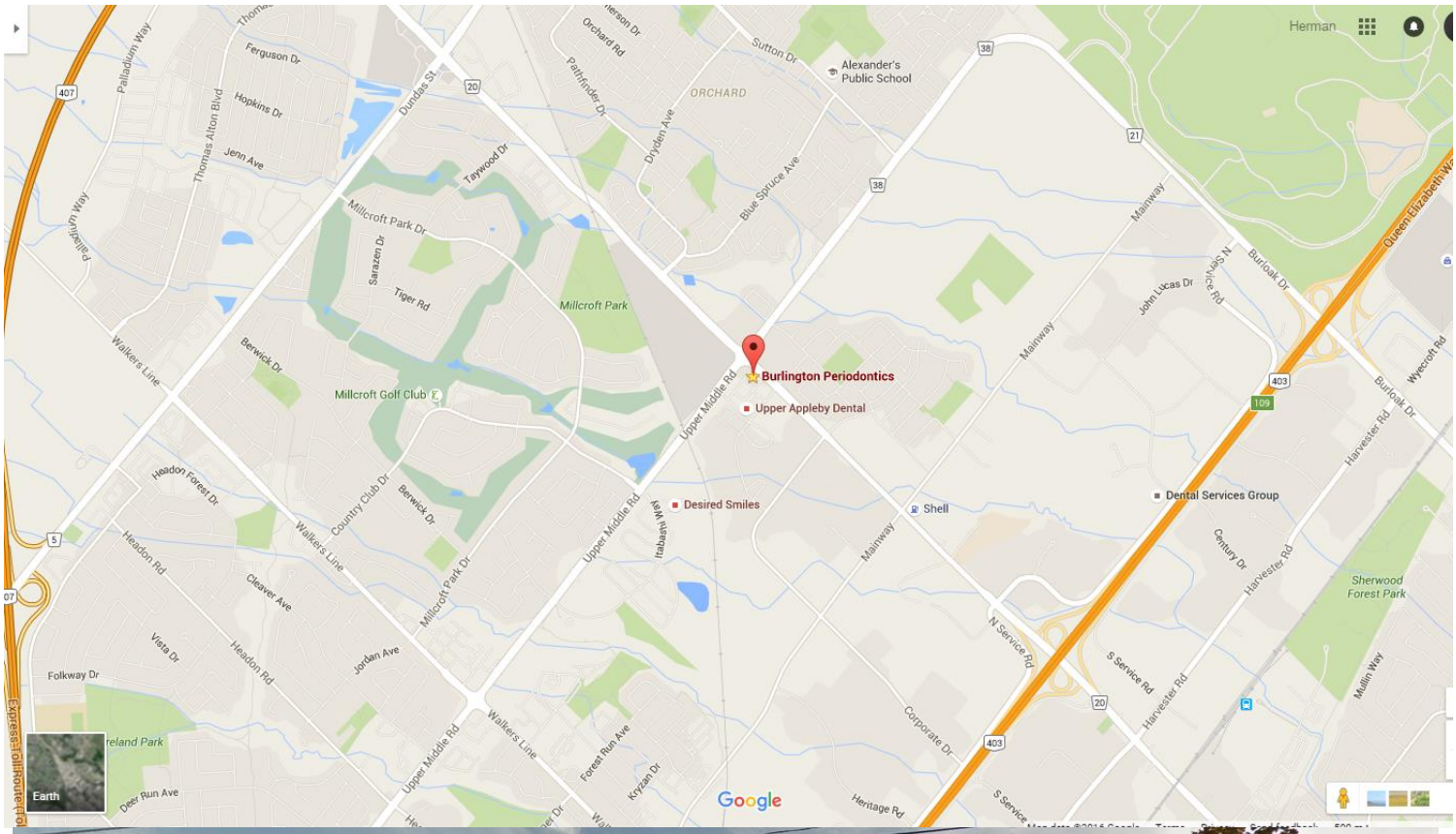


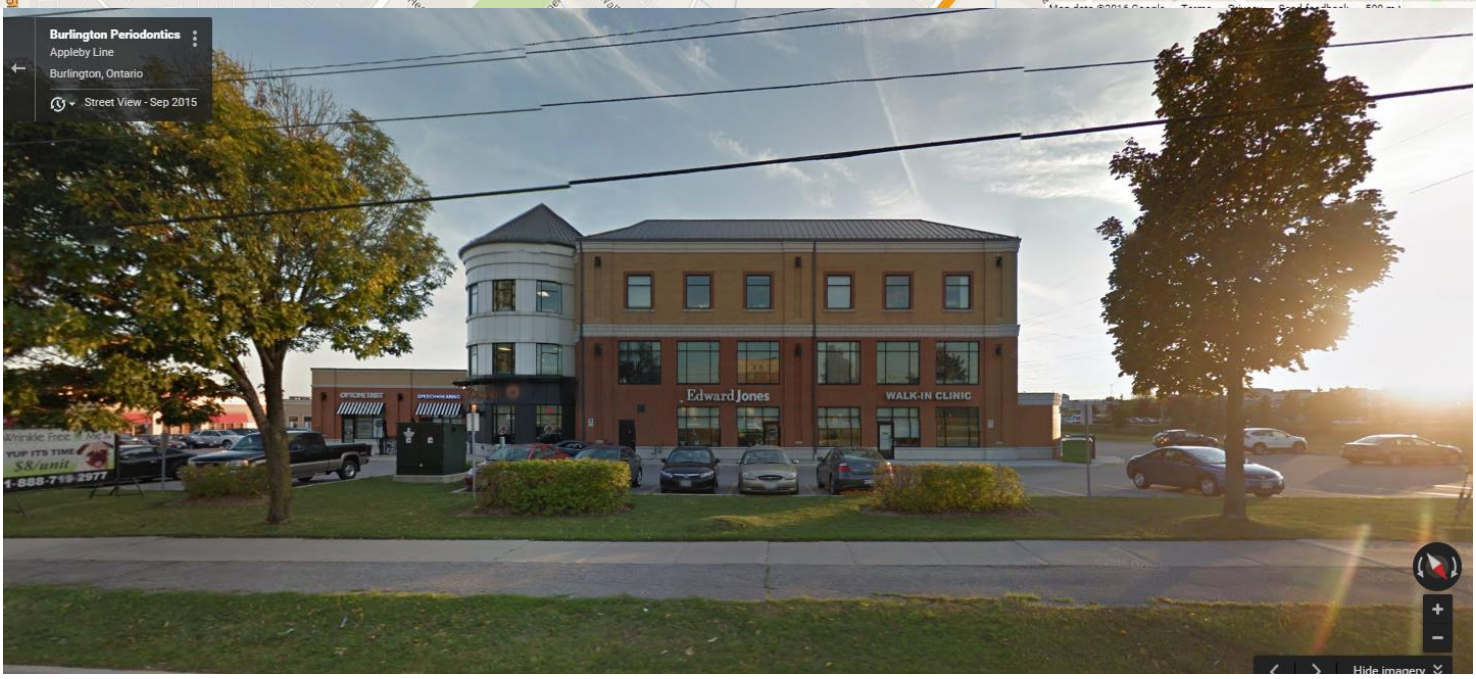


**1960 Appleby Line, suite 21**

We are located on the **South-West corner** of **Appleby Line + Upper Middle Road**
The building is a 3 storey medical building with the Coffee Culture, beside Harveys and Swiss Chalet.
The parking lot can be accessed from **Upper Middle Road coming from the west** or from **Iron Stone drive coming from the south**

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# MEDICAL QUESTIONNAIRE

**ALL INFORMATION GIVEN WILL BE TREATED AS STRICTLY CONFIDENTIAL**

| | |
|---|---|
| Full Name: | Date of birth (mm/dd/yy): |
| Address (please include city): | Postal Code: |
| Home phone number: | Business phone number: |
| Cell phone number: | Email address: |
| Medical doctor's name: | Phone number: |
| Medical doctor's address: | |

**Notes:**

**To provide the best possible care for our patients, all patients are asked to fill out this questionnaire. Please answer the following questions as accurately as possible. If you have any questions, please ask for assistance.**

**1.** Are you being treated for any medical condition at the present or have you been treated within the past year?..... ❑ Yes ❑ No
*If so why?*_____

**2.** Was your last medical check-up within the past one year?…….❑ Yes ❑ No

**3.** Do you have any heart or blood pressure problems?……...❑ Yes ❑ No

**4.** Have you had a heart attack or stroke? ……❑ Yes ❑ No

**5.** Are you taking any medications of any kind? .....❑ Yes ❑ No
*If yes, please list what kinds:-*
_____
_____
_____

**6.** Do you have allergies (e.g. Penicillin? latex?) ……❑ Yes ❑ No
*If yes, please list:-*
_____

**7.** Have you ever had reactions to any medicines or injections? …….❑ Yes ❑ No
*If yes, please list:-*
_____

**8.** Do you have Hepatitis, jaundice or liver disease? ……...❑ Yes ❑ No

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**9.** Do you have any condition that could affect your immune system?
(e.g. Leukemia, AIDS, HIV infection?)…….. ❑ Yes ❑ No

**10.** Do you have any tendency to bruise or bleed easily?..... ❑ Yes ❑ No

**11.** Have you ever been hospitalized for any illness/operations?..... ❑ Yes ❑ No
*If yes, for what:*_____

**12.** Have you had a joint replacement (e.g. knee, hip)…… ❑ Yes ❑ No

**13.** Do you have diabetes?..... ❑ Yes ❑ No

**14.** For women only, are you pregnant?..... ❑ Yes ❑ No

**15.** Have you ever had any of the following?
❑ Chest pain ❑ Shortness of breath ❑ Lung disease
❑ Tuberculosis ❑ Asthma ❑ Cancer ❑ Steroid therapy ❑ Diabetes ❑ Stomach ulcers
❑ Arthritis ❑ Seizures ❑ Kidney disease ❑ Osteoporosis ❑ I.V. bisphosphonates ❑ None

**16.** Do you have any other conditions not listed above?..... ❑ Yes ❑ No
*If yes, for what:*_____

**17.** Are there any diseases or medical problems that run in your family?
(e.g. Diabetes, cancer or heart disease) ……❑ Yes ❑ No
*If yes, what:*_____

**18.** How often do you brush your teeth?_____ How often do you floss your teeth?_____

**19.** Are you nervous during dental treatment? ……❑ Yes ❑ No
*If yes, how nervous are you?* ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ Very nervous

**20.** Is there anything in particular that makes you nervous with dental treatment? ……❑ Yes ❑ No
*If yes, what:*_____

**21.** Do you smoke ❑ Yes ❑ No ❑ Quit # Packs:_____ # Years:_____

**22.** Do you drink alcoholic beverages on a regular basis? ……..❑ Yes ❑ No

**23.** Do you use recreational drugs?.....……❑ Yes ❑ No

I acknowledge that the information given above is true to the best of my knowledge and that the questions have been reviewed with me. Should there be any change to my present health status in the future, I will advise the clinic staff. I have been informed that my physician may be contacted by letter or telephone in order to complete details of my medical history. I hereby consent to my physician providing the clinic with any information in this regard, which may help ensure safe dental treatment.

Signature:_____ Date:_____