

ALTAVIA

DENTAL

WELCOME TO ALTAVIA

We're so glad you're here.

Our goal is to make your dental care feel comfortable, thoughtful and completely personalized. The information below helps us understand your health, your dental history and what matters most to you so we can provide care that fits your needs.

1. ABOUT YOU

Full legal name: _____ Preferred name: _____
Date of birth: _____ Pronouns (optional): _____
Address: _____
City: _____ Province / Postal Code: _____
Mobile phone: _____ Email: _____
If patient is under 18
Parent / Guardian: _____ Relationship: _____
Phone: _____
Emergency Contact
Name: _____ Relationship: _____
Phone: _____

2. GETTING TO KNOW YOU

We believe great dentistry starts by listening.

What brings you to AltaVia Dental today? _____

When was your last dental visit?

Was treatment recommended?

Has anything made dental visits difficult for you in the past?

- | | |
|--|---|
| ☐ Dental anxiety or fear | ☐ Sensitive teeth |
| ☐ Difficulty getting numb | ☐ Strong gag reflex |
| ☐ Time constraints | ☐ Financial concerns |
| ☐ Previous negative dental experience | ☐ Difficulty trusting dental providers |
| ☐ No concerns | ☐ Other: _____ |

If you experience dental anxiety, how would you rate it? 1 2 3 4 5 6 7 8 9 10 (minimal → significant)

What matters most when making decisions about your dental care?

- | | | |
|--|--------------------------------------|---|
| ☐ Comfort | ☐ Oral health | ☐ Function |
| ☐ Appearance | ☐ Longevity | ☐ Preventing future problems |
| ☐ Understanding all options | ☐ Budget | ☐ Other: _____ |

If you could improve anything about your teeth or smile, what would it be? _____

Anything else that would help us make your visits more comfortable? _____

3. YOUR DENTAL HISTORY

Please check Yes or No.

Dental History	Yes	No
Are any of your teeth currently painful?	☐	☐
Are your teeth sensitive to hot, cold, sweets or pressure?	☐	☐
Does food regularly become trapped between your teeth?	☐	☐
Do your gums bleed when brushing or flossing?	☐	☐
Have you noticed swelling, sores or unusual lumps in or around your mouth?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you frequently bite your lips, cheeks or tongue?	☐	☐
Have you noticed any teeth becoming loose or moving?	☐	☐
Do you experience jaw pain, clicking, locking or difficulty opening?	☐	☐
Do you experience frequent headaches or facial pain?	☐	☐
Have you experienced complications following dental treatment or extractions?	☐	☐
Have you received radiation treatment to your head or neck?	☐	☐

Previous Dental Care

☐ Have you ever had orthodontic treatment? ☐ Yes ☐ No

If yes, approximate age / details: _____

☐ Have you ever been treated for gum disease / periodontal disease? ☐ Yes ☐ No

If yes, please describe: _____

☐ Have you ever had dental implants? ☐ Yes ☐ No

☐ Do you wear a nightguard, retainer, denture or other dental appliance? ☐ Yes ☐ No

If yes, please describe: _____

4. YOUR MEDICAL HEALTH

Your overall health can affect your dental care. Please provide as much information as possible so we can treat you safely.

☐ Would you consider yourself to be in generally good health? ☐ Yes ☐ No

☐ Have there been any significant changes in your health during the past year? ☐ Yes ☐ No

If yes, please explain: _____

Family physician / primary care provider: _____

Clinic: _____

Phone: _____

☐ Are you currently under the care of a physician, specialist or other healthcare provider for an ongoing condition? ☐ Yes ☐ No

If yes, please explain: _____

☐ Have you ever been hospitalized or had a significant surgery? ☐ Yes ☐ No

If yes, please describe: _____

5. MEDICATIONS & ALLERGIES

Please include prescription medications, non-prescription medications, vitamins and supplements.

Medication / Supplement	Dose / Frequency

- ☐ I am not currently taking any medications or supplements.
- ☐ Do you have any known allergies or adverse reactions to medications, materials or other substances? ☐ Yes ☐ No

If yes, please list: _____

☐ Latex sensitivity / allergy: ☐ Yes ☐ No ☐ Unsure

6. MEDICAL CONDITIONS

Please check any conditions you currently have or have had in the past. Add details where relevant.

Heart & Circulation

- | | |
|--|---|
| ☐ High blood pressure | ☐ Low blood pressure |
| ☐ Heart attack | ☐ Angina / chest pain |
| ☐ Heart murmur | ☐ Irregular heartbeat / arrhythmia |
| ☐ Heart valve disease or replacement | ☐ Congenital heart condition |
| ☐ Heart failure | ☐ Stroke / TIA |
| ☐ Pacemaker or implanted cardiac device | ☐ Other cardiovascular condition |

Details (condition, treatment / medications, approximate dates if relevant): _____

Respiratory

- | | |
|---|---|
| ☐ Asthma | ☐ COPD / emphysema |
| ☐ Sleep apnea | ☐ Tuberculosis |
| ☐ Other lung / respiratory disease | |

Details (condition, treatment / medications, approximate dates if relevant): _____

Endocrine / Metabolic

- | | |
|--|--|
| ☐ Diabetes - Type 1 | ☐ Diabetes - Type 2 |
| ☐ Thyroid condition | ☐ Adrenal condition |
| ☐ Other endocrine / metabolic condition | |

Details (condition, treatment / medications, approximate dates if relevant): _____

Neurological

- | | |
|---|--|
| ☐ Epilepsy / seizures | ☐ Multiple sclerosis |
| ☐ Parkinson's disease | ☐ History of fainting |
| ☐ Other neurological condition | |

Details (condition, treatment / medications, approximate dates if relevant): _____

Blood / Immune System

- | | |
|---|---|
| ☐ Anemia | ☐ Bleeding or clotting disorder |
| ☐ Easy or prolonged bleeding | ☐ Immunocompromised condition |
| ☐ HIV / AIDS | ☐ Other blood / immune condition |

Details (condition, treatment / medications, approximate dates if relevant): _____

Autoimmune / Inflammatory

- | | |
|---|---|
| ☐ Rheumatoid arthritis | ☐ Lupus |
| ☐ Sjögren's syndrome | ☐ Other autoimmune condition |

Details (condition, treatment / medications, approximate dates if relevant): _____

Bone / Joint Health

- | | |
|--|---|
| ☐ Osteoporosis / osteopenia | ☐ Arthritis |
| ☐ Joint replacement | ☐ Other bone / joint condition |

Details (condition, treatment / medications, approximate dates if relevant): _____

Kidney / Liver / Gastrointestinal

- | | |
|---|--|
| ☐ Kidney disease | ☐ Liver disease |
|---|--|

☐ Hepatitis

☐ Gastrointestinal disease

☐ Other

Details (condition, treatment / medications, approximate dates if relevant): _____

Cancer / Treatment

☐ Current or previous cancer

☐ Chemotherapy

☐ Radiation therapy

☐ Bone marrow or organ transplant

Details (condition, treatment / medications, approximate dates if relevant): _____

Mental Health

☐ Anxiety

☐ Depression

☐ Other condition relevant to dental care

Details (condition, treatment / medications, approximate dates if relevant): _____

☐ Do you have another medical condition not listed above that your dental team should know about? ☐ Yes ☐ No

If yes, please explain: _____

7. ADDITIONAL HEALTH INFORMATION

- ☐ Have you ever experienced unusual or prolonged bleeding? ☐ Yes ☐ No
- ☐ Do you bruise unusually easily? ☐ Yes ☐ No
- ☐ Have you had a significant unexplained weight change recently? ☐ Yes ☐ No

If yes, please explain: _____

Do you currently use any of the following? ☐ Cigarettes ☐ Vaping products ☐ Cannabis ☐ Chewing tobacco / oral nicotine products ☐ Other nicotine products ☐ None

If applicable, frequency: _____

- ☐ Do you currently or previously have a history of substance dependence that may be relevant to medications prescribed during dental treatment? ☐ Yes ☐ No ☐ Prefer to discuss privately

8. BONE & JOINT MEDICATIONS

Have you ever taken medications used to treat osteoporosis, bone loss or certain cancers, including bisphosphonates or similar medications?

Examples may include Fosamax, Actonel, Boniva, Aclasta, Prolia or Xgeva.

- ☐ Yes ☐ No ☐ Unsure

If yes, medication and approximate dates: _____

- ☐ Do you have any artificial / prosthetic joints? ☐ Yes ☐ No

If yes, please specify: _____

9. PREGNANCY & HORMONAL HEALTH

Where applicable:

- ☐ Are you pregnant or is there a possibility you may be pregnant? ☐ Yes ☐ No ☐ Unsure ☐ Not applicable

If yes, approximately how many weeks? _____

- ☐ Are you currently breastfeeding? ☐ Yes ☐ No ☐ Not applicable

- ☐ Are you taking hormonal contraception or hormone replacement therapy? ☐ Yes ☐ No

If relevant, please provide details: _____

10. YOUR COMFORT AT ALTAVIA

Are there any preferences or accommodations that would improve your experience?

- ☐ I prefer a detailed explanation before treatment begins
- ☐ I prefer minimal discussion during treatment
- ☐ Please check in with me frequently during treatment
- ☐ I prefer to know costs before proceeding
- ☐ I experience dental anxiety
- ☐ I have sensory sensitivities
- ☐ I have mobility or accessibility needs
- ☐ I would like to discuss comfort options with the team
- ☐ Other: _____

Anything else you would like us to know? _____

11. ACKNOWLEDGEMENT

I confirm that the information provided in this health history is accurate and complete to the best of my knowledge. I understand that my medical and dental history may affect the dental care I receive and agree to inform AltaVia Dental of any significant changes to my health, medications or medical history.

Patient / Parent / Guardian Name: _____

Signature: _____

Date: _____

THANK YOU FOR SHARING YOUR STORY WITH US.

Welcome to AltaVia Dental.