

Welcome ...to our Dental Office

MEDICAL HISTORY

Name: <i>Mr / Mrs / Ms / Dr:</i>
Date of birth: <i>Day: Month: Year:</i>
Address: <i>City: Prov: Postal Code:</i>
Home #:
Work #:
Cell #:
Email address:
Employer:
Occupation:
How did you hear about us?

MEDICAL ALERT:

Emergency Contact:
Relationship to you:
Daytime Phone #:
Family Doctor:
Phone:
Address:
Dental Insurance?: YES NO
Insurance Company:
Policy #:
Subscriber ID:
S.I.N./Drivers Licence:

The following information is required to enable us to provide you with the best possible dental care. Privacy is enforced and protected by Doctor-Patient confidentiality. The Dentist will review the questions with you and offer clarification if required.

- | | <u>Yes</u> | <u>No</u> | <u>Maybe</u> |
|--|--------------------------|--------------------------|--------------------------|
| 1. Are you taking any medications, non-prescription drugs and/or herbal supplements of any kind? If yes, please list: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies? If you answered yes, please list/circle categories below:
a) medications (penicillin, sulfa, codeine, barbiturates, other)
b) latex/rubber products
c) other (i.e. hay fever, foods, etc) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have or have you ever had asthma? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you or have you ever had any heart or (<i>high / low</i>) blood pressure problems? please explain: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have a prosthetic or artificial joint? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | <u>Yes</u> | <u>No</u> | <u>Maybe</u> |
|---|--------------------------|--------------------------|--------------------------|
| 8. Do you have any conditions or therapies that could affect your immune system (i.e. leukemia, AIDS, HIV, radiotherapy, chemotherapy?) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had hepatitis, jaundice and/or liver disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a bleeding problem and/or bleeding disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been hospitalized for any illness or operations? If yes, please explain:
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. (WOMEN ONLY) Are you pregnant and/or breastfeeding? If so, what is the expected delivery date?
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

13. Do you have or have you ever had any of the following? (Please check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pacemaker | <input type="checkbox"/> steroid therapy |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> stroke | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> cancer |
| <input type="checkbox"/> Diet pill therapy | <input type="checkbox"/> lung disease | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> Seizures (epilepsy) | <input type="checkbox"/> prosthetic heart valve | <input type="checkbox"/> arthritis | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> drug/alcohol dependency | | |

Are there any conditions and/or diseases not listed above that you have currently or have had?

If so, please list: _____

14. What is the reason for today's visit? _____
15. When was your last dental check-up? _____
16. Are you nervous during dental treatment? _____
17. Have you ever had a/any problem(s) with previous dental treatment(s)? _____
18. Are you satisfied with the appearance of your teeth? _____
19. Would you like whiter teeth? _____
20. Do you have any other dental concerns? _____

PATIENT CERTIFICATION AND CONSENT (Parent or guardian should sign for children under 18 years of age)

- I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.
- I consent to the performance of dental and oral surgery procedures as agreed to be necessary or advised.
- I am aware that I am responsible for the entire fee on the day treatment is rendered.
- I understand that my Insurance may not cover all fees incurred during my visit and therefore assume full responsibility for any remaining balance (i.e. deductible, co-payment, difference in fee guide & items that may not be covered by my Plan).
- I understand that any Insurance Plan I may have is an agreement between my employer, my insurance company and myself, and in no way involves my Dentist. Therefore, I am aware that my Dentist may not receive all pertinent information, due to the policies in place by my Insurance company and/or Employer.
- I understand that the Dental Office will make an effort to keep track of my Insurance Plan as a courtesy, and acknowledge that it is ultimately my responsibility to be aware of my plan's details and do not hold my dentist and/or staff responsible for such service(s) and/or any treatment(s) not covered.

DATE: _____/_____/_____

PATIENT SIGNATURE: _____

(Parent or Guardian): _____