Welcome …to the Don Valley Dental Centre

MEDICAL HISTORY

MEDICAL ALERT:

Name:	**Emergency Contact:**
Mr / Mrs / Ms / Dr:	**Relationship to you:**
Date of birth: *Day:* *Month:* *Year:*	**Daytime Phone #:**
Address: **Apt #**	
City: *Prov:* *Postal Code:*	**Family Doctor:**
Home #:	**Phone:**
Work #:	**Address:**
Cell #:	
Email address:	**Dental Insurance?:** **YES** **NO**
	Insurance Company:
Employer:	**Policy #:**
Occupation:	**Subscriber ID:**
How did you hear about us?	**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.

	Yes	No	Maybe
1. Are you taking any medications, non-prescription drugs and/or herbal supplements of any kind? If yes, please list: _____ _____	☐	☐	☐
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)	☐	☐	☐
3. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain: _____ _____	☐	☐	☐
4. Do you have or have you ever had asthma?	☐	☐	☐
5. Do you or have you ever had any heart or (*high / low*) blood pressure problems? please explain: _____ _____	☐	☐	☐
6. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?	☐	☐	☐
7. Do you have a prosthetic or artificial joint? _____	☐	☐	☐

see over →

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

_____

_____

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

☐ *Chest pain/angina*	☐ *shortness of breath*	☐ *pacemaker*	☐ *steroid therapy*
☐ *Heart attack*	☐ *stroke*	☐ *stomach ulcers*	☐ *cancer*
☐ *Diet pill therapy*	☐ *lung disease*	☐ *tuberculosis*	☐ *diabetes*
☐ *Seizures (epilepsy)*	☐ *prosthetic heart valve*	☐ *arthritis*	☐ *kidney disease*
☐ *Thyroid disease*	☐ *drug/alcohol dependency*	☐ *osteoporosis*	

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): _____