WELCOME TO OUR OFFICE

MEDICAL ALERT	

FILE # DATE

NAME _____
LAST FIRST INITIAL

Dr. Mr. Mrs. Miss Ms. Date of Birth _____ Age _____ Marital Status _____

Address _____ Telephone _____
STREET CITY HOME

_____ Telephone _____
PROVINCE POSTAL CODE WORK

Family Physician _____ Telephone _____

Person Responsible for Account _____ Name of Spouse _____

Employer _____ May we call you at work _____

Who referred you to this office _____

In the case of emergency - Notify _____ Relationship _____ Telephone _____

DENTAL INSURANCE

NAME OF SUBSCRIBER _____

DATE OF BIRTH _____ SIN# _____

POLICY # _____ CERTIFICATE # _____

EMPLOYER _____ INSURANCE COMPANY _____

DENTAL HISTORY QUESTIONS

When was your last dental visit? _____ When did you last have dental x-rays? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

	YES	NO
Do you smoke?	☐	☐
Are there any growths or sore spots in your mouth?	☐	☐
Do your gums bleed when brushing or eating?	☐	☐
Are you or have you ever been to a Periodontist (gum specialist)?	☐	☐
Does food catch between your teeth?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you sense you have bad breath?	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐
Do you have emotional concerns about having dental treatment?	☐	☐
Are you dissatisfied with the appearance of your teeth / function / or fit of a denture?	☐	☐

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____
PATIENT SIGNATURE PRINT NAME OF GUARDIAN

The following information is required by the dentist to assist in proper diagnosis and treatment.

ALL INFORMATION IS CONFIDENTIAL

	YES	NO
1. Do you use any prescription or non-prescription medicine regularly?	☐	☐
Specify _____		
2. Have you ever had a serious illness requiring hospitalization or extensive medical care? _____	☐	☐
Specify _____		
3. Have you been hospitalized in the last 5 years?	☐	☐
4. Are you presently under the care of a physician?	☐	☐
If so, explain _____		
5. When was your last complete medical examination?		
6. Do you have any allergic conditions: i.e. asthma, hay fever, skin rash, food or latex allergies?	☐	☐
7. Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea?	☐	☐
Specify _____		
8. Have you ever experienced any unusual reaction to any of the following? (please circle)	☐	☐
local anaesthesia (freezing), aspirin, penicillin, iodine, sulfonamide, barbiturates (sleeping pills).		
or any other medicine? If so, explain _____		

9. Do you have or have you ever had any of the following? please check (✓)

☐ Heart murmur or mitral valve prolapse	☐ Malignant hyperthermia	☐ AIDS	☐ Hepatitis A/B/C	☐ Liver disease
☐ Stomach/intestinal problems	☐ Drug/alcohol addiction	☐ Positive testing for HIV virus	☐ Herpes	☐ Cortisone/steroid therapy
☐ Joint replacement (hip, knee, etc.)	☐ Venereal disease	☐ Jaundice	☐ Heart attack	☐ Other
☐ Mental or nervous disorder	☐ Any lung disease	☐ Diabetes	☐ Cold sores	_____
☐ High/low blood pressure	☐ Thyroid disease	☐ Tuberculosis	☐ Cancer	_____
☐ Hyper (hypo) glycemia	☐ Arthritis or rheumatism	☐ Stroke	☐ Kidney disease	_____
☐ Epilepsy or seizures	☐ Scarlet or rheumatic fever		☐ Sinus trouble	

10. Have you ever had any known contact with the AIDS virus?	☐	☐
11. Has any member of your family had diabetes?	☐	☐
12. Do you bruise easily or bleed abnormally?	☐	☐
13. Have you had any weight changes recently?	☐	☐
14. Do you have any blood disorders such as anemia (thin blood), thalassaemia (major, minor)?	☐	☐
15. Have you ever had radiation treatment or chemotherapy?	☐	☐
If so, explain _____		
16. Have you ever had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐
17. Do you have frequent severe headaches?	☐	☐
18. Do you have frequent earaches, ear/throat infections or any hearing difficulties?	☐	☐
19. Is your eyesight ☐ Good ☐ Adequate ☐ Poor Do you wear contact lenses?	☐	☐
20. Are you on a special diet?	☐	☐
21. Have you ever had any fainting or dizzy spells?	☐	☐
22. Do you ever experience shortness of breath or chest pain when walking or climbing stairs?	☐	☐
If so, explain _____		
23. Have you had any organ transplants or medical implants?	☐	☐
24. Do you have any disease, condition or problem that you think the doctor should know about?	☐	☐
If so, explain _____		
25. WOMEN ONLY Are you pregnant? If so, which month are you in? _____	☐	☐
Are you taking any birth control pills?	☐	☐

TO AVOID COMPLICATIONS, PLEASE NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR MEDICAL CONDITION.

Medical History reviewed by Dr. _____