WELCOME TO OUR DENTAL OFFICE

MEDICAL ALERT

Name: **Dr.☐ Mr.☐ Mrs.☐ Miss☐ Ms.☐**
Last **First** **Initial**

Adult ☐ Child ☐ Date of Birth: ___ / ___ / ___ **DD MM YY**

Marital Status: ________

Address: (Street) (Apt.#) (City) (Postal Code) Tel: ________

Family Physician: ________ Tel: ________

Person Responsible for Account: Self ☐ Other ☐ Name ________ Tel: ________ Ext ____

Your Occupation: ________ Employed by: ________ Tel: ________

Parent or Guardians Name (if Child)): ________ Address if Different: ________

In Case of Emergency Notify: ________ Relationship ________ Tel: ________

Are there any other family members who are patients of our dental office: No ☐ Yes ☐ Who? ________

Who may we thank for referring you to this office? ________

DENTAL INSURANCE YES☐ NO☐

Name of Subscriber: ________ Date of Birth: ________ S.I.N. ____ - ____ - ____

Employer Name: ________ Policy/Certificate: ________

Insurance Company: ________

MEDICAL HISTORY

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

ALL INFORMATION IS CONFIDENTIAL

		YES	NO
1.	Are you in good health?	☐	☐
2.	Have you ever had a serious illness requiring hospitalization or extensive medical care? Please specify: ________	☐	☐
3.	Are you presently under the care of a physician? If so, please explain: ________	☐	☐
4.	Do you use any prescription or non-prescription drugs regularly? Please specify: ________	☐	☐
5.	Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex?	☐	☐
6.	Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? Please specify: ________	☐	☐
7.	Have you ever experienced any unusual reaction to any of the following? (Please circle) local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? If so please explain ________	☐	☐
8.	Have you been warned against taking any drug or medication?	☐	☐
9.	Do you bruise easily or bleed abnormally?	☐	☐
10.	Have you ever had any organ implants or medical implants?	☐	☐
11.	Do you have A.I.D.S. or have you ever tested positive for H.I.V.?	☐	☐
12.	Do you have Hepatitis A, B, or C?	☐	☐
13.	Have you had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐

	Yes	No
14. Do you have any of the following? Please check any that apply	☐	☐

☐ Heart Murmer or Mitral Valve Prolapse	☐ Malignant Hyperthermia	☐ Liver Disease	☐ Herpes
☐ Stomach /Intestinal Problems	☐ Drug / Alcohol Dependency	☐ Heart Attack	☐ Sinus Trouble
☐ Joint Replacement (hip, knee, etc.)	☐ Venereal Disease	☐ Cold Sores	☐ Other:
☐ Mental or Nervous Disorder	☐ Lung Disease (i.e. Asthma)	☐ Jaundice	________
☐ High/low Blood Pressure	☐ Thyroid Disease	☐ Diabetes	________
☐ Hyper (hypo) Glycemia	☐ Arthritis or Rheumatism	☐ Tuberculosis	________
☐ Epilepsy or Seizures	☐ Scarlet or Rheumatic Fever	☐ Stroke	________
☐ Cortisone/Steroid Therapy			

	Yes	No
15. Do you have any disease, condition, or problem that you think the doctor should know about?	☐	☐
16. WOMEN ONLY - Are you pregnant or suspect you might be? If so, what month are you in? ________	☐	☐
Are you taking birth control pills?	☐	☐

DENTAL HISTORY

	Yes	No
1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other ________		
Are you presently having dental pain?	☐	☐
2. How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other ________		
Former dentist: ________ Last dental visit: ________		
Last cleaning: ________ Last Dental x-rays: ________		
3. Do you feel you have bad breath at times?	☐	☐
4. Have you ever had jaw joint surgery or dental implants?	☐	☐
5. Does any part of your mouth hurt when clenched?	☐	☐
6. Have you ever had any bad reactions to local anaesthetic (dental freezing)?	☐	☐
7. Have you had: ☐ Braces ☐ Oral surgery ☐ Gum treatment ☐ Root canal ☐ Teeth Extracted	☐	☐
8. Have you ever experienced any growths or sore spots in your mouth? If so, where?	☐	☐
9. Previous problems with dental treatment? Specify: ________	☐	☐
10. Are you satisfied with the appearance of your teeth? Please specify: ________	☐	☐

____

Office policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it may be necessary to charge for the time lost. Office policy is that services are paid for at each visit as they are performed. However, in certain circumstances arrangements for payment may be made by consulting the doctor.

Patient 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 and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine, and I will assume responsibility for fees associated with these services.

________________________ Date: ___ / ___ / ___ ________________________

(Signature) ☐ PATIENT ☐ PARENT ☐ GUARDIAN DD / MM / YY REVIEWING DENTIST

MEDICAL HISTORY UPDATE DATE:																					
Has there been any change in your medical history?																					
Have you had any serious illness?																					
Are you taking any new medication?																					
Are you under the care of a physician?																					
Have you changed your family physician?																					
Are you pregnant or suspect you might be?																					

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