


Welcome to our Dental Office

Medical Alert 

Mr. Mrs. Ms. Miss Dr. The patient is an Adult Child

Name: (Last) _____ (First) _____ (Initial) _____ Prefer to be called: _____

Address: (Street) _____ (Apt. #) _____ (City) _____ (Postal Code) _____

Home ☎: (____) _____ - _____ Work ☎: (____) _____ - _____ Date of Birth: M _____ D _____ Y _____

Fax: (____) _____ - _____ Other ☎: (____) _____ - _____ Male Female

Employer / School: _____ Occupation: _____

eMail: _____ Whom may we thank for referring you to this office?: _____

Are you likely to be available on short notice for future appointments or appointment changes? Yes No

Family Physician: _____ ☎ (____) _____ - _____

In Case of Emergency Notify: _____ Relation: _____ ☎ (____) _____ - _____

Person responsible for this account: Self Spouse Parent Legal Guardian Other

Name: (Last) _____ (First) _____ (Initial) _____ Relation: _____

Address: (Street) _____ (Apt. #) _____ (City) _____ (Postal Code) _____

Home ☎ (____) _____ - _____ Work ☎ (____) _____ - _____ Drivers License Number _____

Method of Payment Cash Cheque Credit Card : _____ Number: _____ Exp: _____

PRIMARY INSURANCE

Subscriber: _____

Relation: Self Spouse Other: _____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Subscriber I.D. or SIN #: _____

SECONDARY INSURANCE

Subscriber: _____

Relation: Self Spouse Other: _____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Subscriber I.D. or SIN #: _____

MEDICAL HISTORY Please YES or NO to each question.

All information is confidential

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

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever had a serious illness requiring hospitalization or extensive medical care?
Please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently under the care of a physician?
If so, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had a medical examination in the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use any prescription or non-prescription drugs regularly?
Please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea?
Please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you been hospitalized in the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. 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
or any other medicine? If so please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been warned against taking any drug or medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you bruise easily or bleed abnormally? | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT REGISTRATION

MEDICAL / DENTAL HISTORY

MEDICAL HISTORY (Cont'd)Please **YES** or **NO** to each question.**YES** **NO**

11. Have you ever had any organ implants or medical implants? **YES** **NO**
12. Have you ever fainted? **YES** **NO**
13. Do your ankles, feet or hands swell? **YES** **NO**
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? **YES** **NO**
15. Do you have frequent headaches? **YES** **NO**
16. Do you have A.I.D.S. or have you ever tested positive for H.I.V.? **YES** **NO**
17. Do you have or ever had any of the following? **YES** **NO**
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart murmur or Mitral Valve Prolapse | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Stomach /Intestinal Problems | <input type="checkbox"/> Drug / Alcohol Dependency | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Joint Replacement (hip, knee, etc.) | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Mental or Nervous Disorder | <input type="checkbox"/> Lung Disease (i.e. Asthma) | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> High/low Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Hyper (hypo) Glycemia | <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Scarlet or Rheumatic Fever | <input type="checkbox"/> Hepatitis A,B, C | |
| <input type="checkbox"/> Cortisone/Steroid Therapy | <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Other: _____ | |
18. Have you had any injury, surgery or x-ray therapy to your face or jaws? **YES** **NO**
19. Do you have any disease, condition, or problem that you think the doctor should know about? **YES** **NO**
20. WOMEN ONLY: Are you pregnant or suspect you might be? If so, what month are you in? **YES** **NO**
- Are you taking birth control pills? **YES** **NO**

DENTAL HISTORY Please **YES** or **NO** to each question.**YES** **NO**

1. Reason for today's visit: Exam Cleaning Emergency Other _____
- Are you presently having dental pain? **YES** **NO**
- Is there a dental problem you would like to take care of as soon as possible? **YES** **NO**
2. How frequently do you see your dentist? 6 months Yearly Other _____
- Previous Dentist: _____ Last dental visit: _____
- Last cleaning: _____ Full mouth series of x-rays: _____
3. How often do you brush your teeth? _____ Floss? _____ Do you feel you have bad breath? **YES** **NO**
4. Do your gums bleed easily? **YES** **NO**
5. Are your teeth sensitive to: Hot Cold Biting Sweets? **YES** **NO**
6. Do you smoke or use any other forms of tobacco? **YES** **NO**
7. Have you ever had jaw joint surgery? **YES** **NO**
8. Do you have pain in your jaw joints or suffer from migraine headaches? **YES** **NO**
9. Does any part of your mouth hurt when clenched? **YES** **NO**
10. Does your jaw crack or pop when opened widely? **YES** **NO**
11. Have you had: Braces Oral Surgery Gum Treatment Root Canal **YES** **NO**
12. Do you grind or clench your teeth during the day or night? **YES** **NO**
13. Have you ever experienced any growths or sore spots in your mouth? If so, where? **YES** **NO**
14. Previous problems with dental treatment? **YES** **NO**
15. Are you satisfied with the appearance of your teeth? **YES** **NO**
16. Please list any other dental concerns or questions: _____

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.

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 dependents is mine, and I will assume responsibility for fees associated with these services.

(Signature) Patient Parent Guardian_____
Reviewing Dentist

Please Print Name: _____ Date: _____