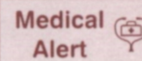
Welcome to our Dental Office

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: ____	☐	☐
2. Are you presently under the care of a physician? If so, please explain: ____	☐	☐
3. Have you had a medical examination in the last year?	☐	☐
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 been hospitalized in the last 5 years? Please specify: ____	☐	☐
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 ____	☐	☐
9. Have you been warned against taking any drug or medication?	☐	☐
10. Do you bruise easily or bleed abnormally?	☐	☐

PATIENT REGISTRATION **MEDICAL / DENTAL HISTORY**

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

	YES	NO
11. Have you ever had any organ implants or medical implants?	☐	☐
12. Have you ever fainted?	☐	☐
13. Do your ankles, feet or hands swell?	☐	☐
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
15. Do you have frequent headaches?	☐	☐
16. Do you have A.I.D.S. or have you ever tested positive for H.I.V.?	☐	☐
17. Do you have or ever had any of the following?	☐	☐

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

	YES	NO
18. Have you had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐
19. Do you have any disease, condition, or problem that you think the doctor should know about?	☐	☐
20. 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 Please ✓ YES or NO to each question.

	YES	NO
1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other ____________		
Are your presently having dental pain?	☐	☐
Is there a dental problem you would like to take care of as soon as possible?	☐	☐
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?	☐	☐
4. Do your gums bleed easily?	☐	☐
5. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets?	☐	☐
6. Do you smoke or use any other forms of tobacco?	☐	☐
7. Have you ever had jaw joint surgery?	☐	☐
8. Do you have pain in your jaw joints or suffer from migraine headaches?	☐	☐
9. Does any part of your mouth hurt when clenched?	☐	☐
10. Does your jaw crack or pop when opened widely?	☐	☐
11. Have you had: ☐ Braces ☐ Oral Surgery ☐ Gum Treatment ☐ Root Canal	☐	☐
12. Do you grind or clench your teeth during the day or night?	☐	☐
13. Have you ever experienced any growths or sore spots in your mouth? If so, where?	☐	☐
14. Previous problems with dental treatment?	☐	☐
15. Are you satisfied with the appearance of your teeth?	☐	☐
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: ____________