MEDICAL HISTORY

Family Doctor ______________________ Phone or Address: ______________________

1. Are you being treated for any medical condition at the present time or within the past year? (Please specify) **Yes/No** ______________________

2. When was your last Medical Exam? ______________________

3. Has there been any changes in your general health in the past year? If yes, please explain. **Yes /No**

____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, list. **Yes /No** ______________________

____

____

5. Do you have any allergies? **Yes/No/Not Sure**

If you answered yes, please list using the categories below.

a) Medications: ______________________

b) Latex / rubber products ______________________

c) Other e.g. hay fever, foods ______________________

6. Have you ever had a peculiar or adverse reaction to any type of anaesthetic? **Yes/No**

7. Have you ever had a peculiar or adverse reaction to any medications or injections?

If yes please explain **Yes/No** ______________________

8. Do you have or have you ever had or been treated for? (CHECK ✔ Y or N)

	Y	N		Y	N		Y	N		Y	N
Respiratory Disease	☐	☐	High Blood Pressure	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Low Blood Pressure	☐	☐	Anemia	☐	☐	Ulcer	☐	☐
Scarlet Fever	☐	☐	Abnormal Bleeding	☐	☐	Sinus	☐	☐	Epilepsy	☐	☐
Shortness of Breath	☐	☐	Nervous Problems	☐	☐	Arthritis	☐	☐	Asthma	☐	☐
Thyroid Problems	☐	☐	Blood Disorders	☐	☐	Diabetes	☐	☐	Heart Murmur	☐	☐
Kidney Problems	☐	☐	Venereal Disease	☐	☐	Cancer	☐	☐	Tuberculosis	☐	☐
Psychiatric Problems	☐	☐	Artificial Joints	☐	☐	Pacemaker	☐	☐	Dizzy Spells	☐	☐
Heart Disease	☐	☐	Liver Problems	☐	☐	Chest Pain	☐	☐	Hepatitis	☐	☐
General Allergies	☐	☐	AIDS or HIV Positive	☐	☐	Disease of Eyes, Ears, Nose, or Throat				☐	☐

9. Have you ever been hospitalized for any illness or operations? If yes, please explain. **Yes/No**

____

10. Have you had any diseases or conditions not listed above? If yes, please list. **Yes/No**

____

11. Do you smoke or chew tobacco products? **Yes/No** If yes, how much? ______________________

12. For Women Only: Are you breast feeding or pregnant? **Yes/No** If pregnant, how far along are you?

____

To the best of my knowledge, the above information is correct, and to my knowledge, I have not omitted any pertinent information.
I will assume responsibility for fees associated with my procedures/treatments performed. Should any cheque be returned for any reason, bank and administration charges will be applied. A fee may be charged to my account for missed/cancelled appointments without 48 hours notice, I authorize release, to my dental benefits/plan administrator and the CDA information contained in claims submitted electronically.

Patient / Parent / Guardian Signature: ______________________ **Date** ____________

Dentist's Signature: ______________________ **Date** ____________

X-ray services, dental auxiliary services, and other technical services provided at our facility are provided by Azzi, Ivanita, Jamshaid, Rodrigues Dentistry Professional Corporation, a company owned and operated respectively by Dr.'s R. Azzi, C.A. Ivanita, A. Jamshaid and E. Rodrigues.

CONFIDENTIAL PATIENT INFORMATION

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by Doctor-Patient confidentiality. The dentist will review your responses and explain any questions you do not understand. Please fill in the entire form and feel free to ask for help in completing it.

DATE: ______________________

Welcome to our office. Whom may we thank for referring you, or how did you hear about us?

____

Do you require antibiotics for medical/dental treatments? Yes/No

NAME: Dr./Mr./Mrs./Ms./Miss: ____

(First Name) (Last Name) (Middle Name)

Date of Birth: ______________________________

Address: ____________________ Town/City: __________ Prov. ____ Postal Code: _______

Home Phone: ____________________________ Work Phone: ____________________

Cell Phone: ____________________________ Email: ________________________

Preferred method of communication: Home Phone/Work Phone/Cell Phone/Email

If your preferred method of communication is email, by indicating so, you consent to receive emails from our office, as well as our automated communication system, EasyMarkit. Please note that at any time you may opt out of our automated system, or have the office remove your email from your file.

Please list other family members attending this office:

____

____

In case of emergency contact: ____

Employer/School: ______________________ Occupation: ______________________

Do you have dental insurance? **Yes/No** Name of Company: ____________________

Plan # ____________________ Certificate# ______________________________

Do you have dual insurance coverage? **Yes/No** ______________________________

____

DENTAL HISTORY

1. Are you currently experiencing a specific dental problem? Are you in any discomfort at this time?

____

____

2. Have you been under regular care by a Dentist? When was you last visit? What was done at this time? ____

____

3. What is the name of your previous Dentist? Do you have recent x-rays? ________________

4. Are you nervous during dental treatment? **Yes/No** Would you be interested in sedation for your dental appointments? **Yes/No**

5. How often do you brush your teeth? __________ How often do you floss? __________

6. Do you currently experience any of the following?

☐ loose teeth	☐ bleeding/sore gums	☐ sensitive teeth
☐ bad breath	☐ earache	☐ popping/clicking in jaw joints
☐ headache	☐ gagging	☐ spaced/crooked teeth
☐ neck pain	☐ missing teeth	☐ unexplained nose bleeds

7. Are you happy with your smile? **Yes/No**

8. If you are not happy with your smile, what would you like done?

____

____

____

PLEASE COMPLETE OTHER SIDE