WELCOME TO OUR DENTAL OFFICE

MEDICAL ALERT

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ ADULT ☐ CHILD ☐ Marital Status _____

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

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

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ X ____ Date of Birth: ____ / ____ / ____

Fax: (____) ____ - ____ Other: (____) ____ - ____ X ____ ☐ Male ☐ Female

Employer/School: Occupation: _____

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

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

Family Physician: _____ Phone: (____) ____ - ____

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

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

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

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

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ X ____ _____

Primary Insurance

Subscriber: _____ Date of Birth: _____
Relation: _____ Other: _____
Insurance Co: _____
Policy/Plan #: _____ Division/Sect #: _____
Subscriber I.D: _____ SIN: _____
Are you Familiar with Your Plan Details? ☐ Yes ☐ No

Secondary Insurance

Subscriber: _____ Date of Birth: _____
Relation: _____ Other: _____
Insurance Co: _____
Policy/Plan #: _____ Division/Sect #: _____
Subscriber I.D: _____ SIN: _____
Are you Familiar with Your Plan Details? ☐ Yes ☐ No

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

Medical History

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?	☐	☐
2.	Please specify: _____		
3.	Are you presently under the care of a physician?	☐	☐
4.	If so, please explain: _____		
5.	Have you had a medical examination last year?	☐	☐
6.	Do you use any prescription or non-prescription drugs regularly?	☐	☐
	Please specify: _____		
7.	Do you have any allergic condition e.g. hay fever, skin rash, food allergies, metal, latex?	☐	☐
8.	Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea?	☐	☐
	Please specify: _____		
9.	Have you been hospitalized in the last 5 years?	☐	☐
	Please specify: _____		
10.	Have you ever experience any unusual reaction to any of the following? (Please circle)	☐	☐
	Local anaesthesia (freezing), aspirin, penicillin, codeine, salpha drugs, barbiturates (sleeping pills), or Any other medicine? If so please explain.		
11.	Have you been warned against taking any drug or medicine?	☐	☐

	YES	NO
12. Have you ever had any organ implants or medical implants?	☐	☐
13. Have you ever fainted?	☐	☐
14. Do your ankles swell?	☐	☐
15. Do you experience shortness of breath or chest pain when talking or climing stairs?	☐	☐
16. Do you have frequent headaches?	☐	☐
17. Do you have A.I.D.S or have you ever tested positive for H.I.V?	☐	☐
18. Do you have any of the following? Please check any that apply	☐	☐

☐ Heart Murmur or Mitral Valce Prolapse	☐ Malignant Hyperthermia	☐ Epilepsy or Seizures	☐ Herpes
☐ Stomach/Intestinal Problems/Ulcers	☐ Drug/Alcohol Dependency	☐ Liver Disease	☐ Sinus Trouble
☐ Joint Replacement (Hip, Knee, Etc.)	☐ Venereal Disease	☐ Heart Attack	☐ Stroke
☐ Mental or Nervous Disorder	☐ Lung Disease (i.e.Asthma)	☐ Cold Sores	☐ Kidney Problems
☐ High Blood Pressure	☐ Thyroid Disease	☐ Jaundice	☐ Emphysema
☐ Low Blood Pressure	☐ Arthritis or Rheumatism	☐ Tuberculosis	☐ Glaucoma
☐ Hyper (hypo) Glycemia	☐ Scarlet or Rheumatic Fever	☐ Hepatitis A,B,C	☐ Diabetes
☐ Cortisone/Steroid Therapy	☐ Cancer'Chemotherapy	☐ Other _____	☐

19. Have you had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐
20. Do you have any disease condition, or problem that you think the doctor should know about?	☐	☐
21. WOMEN ONLY – Are you pregnant or suspect that you might be? If so, what month are you in? _____	☐	☐
Are you taking birth control pills?	☐	☐
Are you nursing?	☐	☐

DENTAL HISTORY

	YES	NO
1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other		
Are you presently having dental pain?	☐	☐
Is there a dental problem you would like to take care of as soon as possible?	☐	☐
Please specify: _____		
2. How frequently do you see your dentist? ☑ 6 months ☑ Yearly ☑ Other _____		
Last dental visit: _____		
Last cleaning: _____ Full mouth series of x-rays: _____		
3. How often do you brush your teeth? _____ Floss: _____		
4. Do you gums bleed easily?	☐	☐
5. Are you teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets?	☐	☐
6. Do you feel you have bad breath at times?	☐	☐
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 haw 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. Do you smoke? Number per day: _____	☐	☐
14. Do you or does any family member have a problem with snoring?	☐	☐
15. Have you ever experience any growth or sore spots in your mouth? If so, where?	☐	☐
16. Previous problems with dental treatment? Specify: _____	☐	☐
17. Are you satisfied with the appearance of your teeth?	☐	☐
Please specify: _____		
18. Other Dental Concerns _____		

Privacy Act Notification: I have been informed of the privacy policy of this office and undestand that all information I have supplied will be used and discloed as set out within this office policy.
Office Policy: Your Appointment time will be reserved for you. If you are unable to keep the appointment we will require 24 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 to receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnosis procedures and treatment as may be necessary for proper dental care. I also understand the 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.

_____ Date MM/DD/YY

(Signature) ☑ PATIENT ☑ PARENT ☑ GUARDIAN REVIEWING DENTIST