Welcome To Our Dental Office

FILE # **MEDICAL ALERT** Date: _____ , ___

Name: Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ (Last / First / Initial) Adult ☐ Date or Birth: _____ , ___ Child ☐ Age: _____ Marital Status: ____

Address: _____ (Street / City / Prov / Postal Code) Tel: _____ (Home) _____ (Work) ____ (Ext.)

Reason for todays' visit: Examination ☐ Emergency ☐ Other ☐ _____

Family Physician: _____ Tel: _____

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

Address: _____

Your Occupation: _____ Employed by: _____ Tel: _____ Ext ____

Spouses Occupation: _____ Employed by: _____ Tel: _____ Ext ____

If a Child (Parent or Guardians Name): _____ Address (If Different): _____

In Case of Emergency Notify: _____ Relationship: _____ Tel: _____ Ext ____

Names of other family members who are patients at our office: _____

Who referred you to this office? _____

DENTAL INSURANCE YES ☐ NO ☐

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

Employer/Group Policy Holder: _____ Insurance Year End: _____ , ___ Certificate: _____

Employer Name: _____ Address: _____ Tel: _____

Insurance Company: _____ Tel: _____

Coverage: Maximum a Year $ _____ Deductible $ _____ Coverage: Basic ____ % Endo _____ % Perio ____ % Major __ %

MEDICAL HISTORY

Please check the appropriate box:
Yes - Y **Maybe/Not Sure - ?** **No - N**

	Y	?	N
1) Are you presently under the care of a physician for any medical condition? If yes please specify: _____ Physicians' Name: Tel:			
2) Are you taking or have you recently taken **any** prescription or non-prescription drugs. If the answer is yes, please list them:			
3) Do you or have you ever had any heart or blood pressure problems (e.g. heart attack, heart murmur, mitral valve prolapse, angina, heart pacemaker, high or low blood pressure)?			
4) Do you experience shortness of breath or chest pains when taking a walk or climbing stairs?			
5) Have you ever been hospitalized for any serious illnesses or operations?			
6) Have you ever had treatment for a tumor or growth (e.g. radiation, surgery, chemotherapy)?			
7) **For women only:** Are you taking birth control pills?			
8) Time since your last medical check-up? _____ Time since your last visit to a physician? _____ Reason for visit:			
9) Have you ever experienced an allergic or other bad reaction to a medication, injection, material or food of any kind (e.g. penicillin, aspirin or local anesthetics, "dental freezing", metals, latex)?			
10) Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut?			
11) Do you have any conditions that could affect your immune system (e.g. AIDS, HIV positive, leukemia, etc.)?			
12) Do you have or have you ever had jaundice, hepatitis (A, B or C), or liver disease?			
13) Do you smoke, chew tobacco, or use a trans-dermal nicotine patch?			
14) **For women only:** Are you pregnant or suspect you might be? If so what is the expected delivery date? _____ , ___			

MEDICAL HISTORY (con't)

15) Has the **Child Patient** recently had any of the following: ☐ Mumps ☐ Chicken Pox ☐ Measles ☐ Strep Throat ☐ Tonsillitis — Y ? N

16) Do you have any hearing difficulties? — Y ? N

17) Do you have or have you ever had any blood disorders (e.g. anemia, sickle cell disease, etc.)? — Y ? N

18) Do you or does any member of your family have diabetes? — Y ? N

19) Do you have or have you ever had any of the following? Please check off any that apply. — Y ? N

☐ Chest Pain ☐ Bronchitis ☐ Tuberculosis ☐ Arthritis ☐ Sinus Trouble ☐ Stomach Ulcers
☐ Asthma ☐ Stroke ☐ Cancer ☐ Glaucoma ☐ Lung Disease ☐ Kidney Disease
☐ Venereal Disease ☐ Prosthetic Implant ☐ Alcohol Dependency
☐ Epilepsy or Seizures ☐ Fainting or Dizzy Spells ☐ Rheumatic / Scarlet Fever
☐ Circulation Problems ☐ Drug Dependency ☐ Mental / Nervous Disorder or Psychiatric Treatment

20) Is there anything the doctor should know about your medical history that has not been mentioned? Please specify:

To the best of my knowledge, the above information is correct. Reviewed by Treating Dentist

☐ _____ _____, ___ ☐ _____ _____, ___

(Patient's Signature) Date (Signature of Treating Dentist) Date

DENTAL HISTORY

1) How long since your last visit to the dentist? ____ Yrs. ____ Mths. — Y ? N

2) Did you receive dental x-rays at that time? — Y ? N

3) Did you have your teeth cleaned? — Y ? N

4) Have you ever had local anaesthetic (freezing)? Any complications? If yes please specify: — Y ? N

5) Are you satisfied with the appearance of your teeth? If not, please specify: ☐ Colour ☐ Gaps ☐ Size ☐ Shape ☐ Chips ☐ Other — Y ? N

6) Have you ever had any of the following dental treatments (please check): ☐ Crowns or Caps ☐ Bridgework ☐ Orthodontics ☐ Root Canal ☐ Gum Surgery ☐ Full or Partial Dentures — Y ? N

7) Do you have any emotional concerns about having dental treatment? — Y ? N

8) Have you ever received oral hygiene instruction in: ☐ Brushing ☐ Flossing ☐ Other — Y ? N

9) Do your gums bleed when: ☐ Brushing? ☐ Flossing? — Y ? N

10) Do your gums feel swollen or tender? — Y ? N

11) Do you feel that you have bad breath? — Y ? N

12) Do you grind or clench your teeth? — Y ? N

13) Does food routinely catch between your teeth? — Y ? N

14) Have you ever had any problem with previous dental work? — Y ? N

15) Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Other? Specify other: — Y ? N

16) Please note any other dental concerns you have:

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 if 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: _____, ___

(Signature) ☐ PATIENT ☐ PARENT ☐ GUARDIAN

Health History Updates **Date:** _____ _____ _____ _____ _____ _____ _____ _____

Have you changed your family physician?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Are you under the care of a medical specialist?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Are there any changes to your health history?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Please update Question 2 of your Medical History: Note any changes to the list of prescription or non-prescription drugs being used.

Patient's Initials: _____ _____ _____ _____ _____ _____ _____ _____

Doctor's Initials: _____ _____ _____ _____ _____ _____ _____