INFORMATION AND MEDICAL HISTORY

Name:_____ Date of Birth: _____

Address:_____ Phone No.: _____

City:_____ Postal Code:_____ Office No.: _____

E-mail:_____ Cell No.: _____

Preferred method of contact for appointment and/or recall reminders: ❑ phone ❑ e-mail ❑ mail

Occupation:_____ Family Doctor: _____

How did you hear about our practice? _____

Emergency Contact:_____ Phone No.: _____

Person Responsible: ❑Self ❑Insurance (please fill out ***Insurance Information*** Form) ❑Other

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. Your dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

_____

When was your last medical checkup?

_____

Has there been any change in your general health in the past year? If yes, please explain.
❑ YES ❑ NO ❑ NOT SURE/MAYBE

_____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
❑ YES ❑ NO ❑ NOT SURE/MAYBE

_____

Do you have allergies? If you answered yes, please list the categories below:
❑ YES ❑ NO ❑ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

_____

Have you ever had a peculiar or adverse reaction to any medications or injection? If yes, please explain
❑ YES ❑ NO ❑ NOT SURE/MAYBE

_____

Do you have or have you ever had asthma? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

_____

Do you have or have you ever had any heart or blood pressure problems?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

_____

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

_____

Do you have a prosthetic or artificial joint? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

_____

Have you ever been advised by your doctor to take antibiotics before dental treatment?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

Do you have any conditions or therapies that could affect your immune system? (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)
❑ YES ❑ NO ❑ NOT SURE/MAYBE

Have you ever had hepatitis, jaundice or liver disease? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

Do you have a bleeding problem or bleeding disorder? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

Have you ever been hospitalized for any illness or operations? If yes, please explain.
❑ YES ❑ NO ❑ NOT SURE/MAYBE

Do you have or have you ever had any of the following? Please check.

❑ chest pain, angina	❑ steroid therapy	❑ diabetes	❑ tuberculosis	❑ cancer
❑ shortness of breath	❑ seizures (epilepsy)	❑ kidney disease	❑ stomach ulcers	❑ arthritis
❑ pacemaker	❑ heart attack	❑ stroke	❑ thyroid disease	❑ diet pill therapy
	❑ lung disease	❑ prosthetic heart valve	❑ drug/alcohol dependency	

Are there any conditions or disease not listed above that you have or have had? If so, please specify?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

Are there any disease or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
❑ YES ❑ NO ❑ NOT SURE/MAYBE

Do you smoke or chew tobacco products? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

Are you nervous during dental treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

What do you like about your smile?_____

What would you like to change on your smile?_____

What brings you in today?_____

For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct. This is to certify that I, undersigned, understand and agree with what I have read and consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local or general anesthesia, or any drug. I agree to make payment for service upon completion by cash, cheque, or credit card unless otherwise specified.

Patient/Parent/Guardian Signature:_____Date: _____

DENTIST'S NOTES: