

MEDICAL & DENTAL HISTORY

Personal History (Please Print)

Date: _____

Patient's Name: _____ Preferred Name: _____

Home Address: _____ City: _____

Province: _____ Postal Code: _____

Phone: _____
Home Work Cell

Date of Birth: ____/____/____
dd / mm / yyyy

Email: _____

Health Card #: _____

How did you hear about us? _____

Are you covered under any dental coverage? **Yes or No** Name of Insurance: _____

In case of Emergency, we should notify:

Name: _____ Relationship _____ Phone # _____

Name of Family Doctor _____ Doctor's Phone # _____

Do you have a medical specialist? **Yes or No**

If yes, name and phone number _____

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 the questions and explain any you don't understand.

1. Are you being treated for any medical conditions, broken bones or surgeries at the present or within the past year?
Any new diagnosis? **Yes or No**

If yes, please explain: _____

2. When was your last medical check-up? _____

3. Has there been any change in your general health in the past year? **Yes or No**

If yes, please explain: _____

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

If yes, please list:

5. Are you using Cannabis? **Yes or No**

If yes, please explain: Medical or recreational? What form? How much? Last dose?

6. Have you ever had a peculiar or adverse reaction to a medication or injection? Latex? Food allergies?

Environmental? **Yes or No**

If yes, please explain: _____

7. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. Infective Endocarditis), a heart condition from birth (i.e. Congenital Heart Disease) or a heart transplant? **Yes or No**

8. Do you have a prosthetic or artificial joint? **Yes or No**
If yes, have you been advised to take antibiotics before dental appointments? **Yes or No**
9. Have you ever had hepatitis, jaundice or liver disease? **Yes or No**
10. Do you have a bleeding problem or bleeding disorder? **Yes or No**
11. Have you ever been hospitalized for any illness or operations? **Yes or No**
If yes, please explain: _____

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

Allergy - Codeine	Diabetes	High Cholesterol	Rheumatism
Allergy - Iodine	Dizziness/Fainting	HIV+ (AIDS)	Rheumatoid Arthritis
Allergy - Aspirin	Dementia	Hives	Sinus Problems
Allergy - Latex	Emphysema	Hypertension	Skin Rash
Allergy - Penicillin	Epilepsy	Hypo/Hyper Glycemic	Smoking
Allergy - Sulfa	Excessive Bleeding	Jaundice	STDs
Allergy - Erythromycin	Excessive Bruising	Kidney Disease	Stomach Problems
Allergy - Local Anesthetic	Glaucoma	Liver Disease	Stroke
Alzheimer's	Hard to freeze	Lupus	Thyroid Disease
Anemia	Hay Fever	Mental Disorders	TMJ
Arthritis	HBP/LBP	Multiple Sclerosis	Tuberculosis
Artificial Joints	Head Injury	Nervous Disorders	Tumors
Asthma	Hearing Disabled	Pacemaker	Ulcers
Blood Disease	Heart Disease	Radiation Treatment	
Blood Thinners	Heart Murmur	Respiratory Problems	
Cancer	Hepatitis A, B, C	Rheumatic Fever	

13. Are there any conditions or diseases not listed above that you have or have had? **Yes or No**
If yes, please explain: _____

14. Have you had previous dental care? **Yes or No**

How long ago? _____ Last dental cleaning? _____ Last x-rays? _____

15. Who was your last dentist? _____

16. Are there any disease or medical problems that run in your family? **Yes or No**
If yes, please explain _____

17. Do you smoke or chew tobacco products? **Yes or No**

18. Are you nervous about dental treatment? **Yes or No**

19. Have you had an unpleasant dental visit? **Yes or No**
If yes, please explain: _____

20. **For Women Only:** Are you breastfeeding or Pregnant? **Yes or No**
If pregnant, what is the expected delivery date? _____

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect information has the potential of being hazardous to my health.

I authorize the diagnosis of dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance, payers, and/or health practitioners.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents. (if any).

Signature of patient, parent, or guardian: _____