Confidential Patient Information and Medical History

(Please print)

Patient Name: ________________________________ Date of Birth (dd/mm/yyyy): _____________

Home Address: ____

City: ____________________________ Postal Code: ___________

Home Telephone: _________________ Cell Telephone: ______________________________

Best Phone Number to Contact You: _________________

E-Mail Address: _________________________________ Marital Status: ___________________

Employer: _________________________ Occupation: __________________________________

Business Address: ____

Business Telephone: _______________________________________

Name of your general dentist: ___________________ Referred by: ______________________

Do you have dental insurance? ☐ Yes ☐ No

In case of an emergency, contact:

Name: _________________________ Relationship: ____________ Phone Number: __________

Family Physician's Name: ____________________________ Phone Number: ________________

Pharmacy: ____ Phone Number: ________________

My last physical examination was: __________________ Are you in good health? ☐ Yes ☐ No

Has there been any change in your health in the last year? ☐ Yes ☐ No

If so, please elaborate. ____

Has it ever been recommended that you routinely have antibiotic coverage before surgery or dental treatment? ☐ Yes ☐ No

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.

____

____

____

____

ARE YOU CURRENTLY TAKING ANY MINERAL, VITAMIN AND/OR HERBAL SUPPLEMENTS? IF SO, PLEASE SEE BLUE SHEET.

ALLERGIES - Are you allergic or have you reacted adversely to any of the following?

	Yes	No		Yes	No
Aspirin			Codeine or other narcotics		
Penicillin			Sedatives or sleeping pills		
Tetracycline			Local Anesthetics		
Other antibiotics			Latex gloves		
Other allergies (please list):					

Do you smoke? ☐ **Yes** ☐ **No**

If so, how many cigarettes/day? _______ How many years have you smoked? _______

Are you a former smoker? ☐ **Yes** ☐ **No**

If so, how many cigarettes/day? _______ How many years did you smoke? _______

How long ago did you quit? _______

Do you have or have you had any of the following conditions?

	Yes	No		Yes	No
High Blood Pressure/Heart Trouble			Sleep Apnea		
Angina Pectoris			Artificial Joint		
Mitral Valve Prolapse (MVP)			Kidney Trouble		
Heart Murmur			Stomach Ulcer/ Acid Reflux		
Artificial Heart Valve / Pacemaker			Glaucoma		
Heart Surgery or Heart Attack			Liver Disease		
Anemia			Hepatitis A/B/C		
Excessive Bruising			Yellow Jaundice		
Thyroid Disease			Leukemia		
Hemophilia or Blood Transfusion			HIV (AIDS)		
Persistent Cough			Venereal Disease		
Emphysema/Bronchitis			Cold Sores		
Asthma			Recreational Drug Use		
Tuberculosis			Alcohol Dependency		
Hayfever			Fainting		
Sinus Troubles			Eating Disorders		
Diabetes or Excessive Thirst			Psychiatric Treatment		
Arthritis			Epilepsy/Seizures		
Cancer			Stroke		
Osteoporosis			Rheumatic or Scarlet Fever		

	Yes	No
Have you ever been hospitalized? If so, what was the illness or operation?		
Are there any medical conditions that run in your family? (ie. High blood pressure, diabetes, cancer)		
Have you ever had abnormal bruising or bleeding associated with previous extractions, surgery or injuries?		
Have you had any serious trouble with any previous dental treatment?		
Do you have any disease, condition or problem not listed above you think we should know about?		
Women only: Are you pregnant? If so, what month are you due? _____________ Are you nursing?		

Are you willing to spend 15 minutes a day to keep your teeth a lifetime? ☐ Yes ☐ No

On a scale of 1 to 5, how nervous are you about dental treatment? *(Please circle)*

(Not nervous at all) 1………..2……….3………..4…………5 (very nervous)

I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge. I consent to your obtaining, from other practitioners who are currently treating me or have treated me, such further information as may be necessary for providing me with proper dental treatment and care.

Signature: _______________________________ Date: __________________

D.D.S.: ___________

Please be advised that our office policy is not to accept assignment of benefits as payment for accounts.