Date: ____________________

Medical Alert: [ ]

MEDICAL HISTORY

The information in this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly CONFIDENTIAL and will remain with the office. Our receipt is available to assist you with the completion of this form. Thank you!

PERSONAL INFORMATION

NAME: LAST FIRST MIDDLE		HOME PHONE: INCLUDE AREA CODE ( )	BUSINESS/CELL PHONE: ( )
NAME OF GUARDIAN:			
ADDRESS (HOME):	CITY:	PROVINCE:	POSTAL CODE:
EMAIL:	DATE OF BIRTH: (DD/MM/YY)	AGE: SEX: M / F	HEIGHT: WEIGHT:
OCCUPATION:	MARITAL STATUS:		
EMPLOYER:	NO. OF YEARS EMPLOYED:	MAY WE CALL YOU AT WORK? **YES / NO**	
WHO REFERRED YOU TO OUR OFFICE?			

EMERGENCY CONTACT

NAME:	RELATIONSHIP:	Home Phone: ( )	Cell Phone: ( )
NAME OF FAMILY DOCTOR:			
PHONE / ADDRESS:			

CHILDREN ONLY

SCHOOL:	GRADE:	FAVOURITE TOY/SPORT:
BROTHERS / SISTERS:		

WOMEN ONLY

	YES	NO
Are you or could you be pregnant?		
Nursing?		
Taking birth control pills or hormonal replacement?		

MEDICAL HISTORY QUESTIONAIRE

Please (X) a response to indicate if you have or have not had any of the following diseases, medical conditions or problems

	YES	NO		YES	NO		YES	NO
Abnormal bleeding			Epilepsy or seizers			Lung disease		
AIDS or HIV infection			Fainting or dizzy spells			Mental/nervous disorder		
Alcohol dependence			Gastrointestinal disease			Mitral valve prolapse		
Anemia			Glaucoma			Osteoporosis		
Arthritis			Head/neck injuries			Psychiatric disorder		
Artificial heart valve Stroke			Heart disease or attack			Rheumatic/Scarlet fever		
Artificial joints (hips, knees)			Heart murmur			Severe headaches/migraines		
Asthma			Heart rhythm disorder			Severe or rapid weight loss		
Blood disorders			Heart pacemaker			Sexually transmitted disease		
Bronchitis			Hepatitis A/B/C			Sickle cell anemia		
Cancer			Herpes			Sinus trouble		
Chemotherapy			High/low blood pressure			Sleep disorder		
Congenital heart lesion			Hodgkin's disease			Thyroid disease		
Cortisone/steroid			Jaundice			Tuberculosis		
Diabetes			Kidney disease			Ulcers		
Drug dependence			Leukemia			venereal disease		
Emphysema			Liver disease			Other____________________		

	YES	NO
Do you currently have, or have had in the past, any disease, condition or problem not listed above?		
Is there anything else about your health we should be made aware of?		
Do you wish to speak to the Doctor privately about any problem or medical condition?		

PLEASE NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

DENTAL HISTORY

Date of your last dental visit: ______________________ Date of your last dental cleaning: ______________________

Date of your last full mouth X-rays: ______________________

1. Do you use dental floss? How often? ______________________
2. How often do you brush your teeth? ______________________
3. Are you having any pain or are you aware of any dental problem? ______________________
4. Do you currently experience: (Please (X) a response to the appropriate one)

Loose teeth	☐	Bleeding gums	☐	Sore gums	☐
Sensitive teeth	☐	Bad breath	☐	Popping or clicking	☐
Ear ache	☐	Neck pain	☐	In the jaw joints	☐
Headache	☐	Unexplained nose bleed	☐	Missing teeth	☐
Spaced or crooked teeth	☐	Unsatisfactory dentures	☐	gapping	☐

5. Do you have any questions or concerns? ______________________

OFFICE POLICIES

A service charge of 4% per month may be charged to accounts exceeding 30 days. There will may be a monetary charge for appointments cancelled without at least 48 hours advance notice from the time of the scheduled appointment. We cannot guarantee appointments for patients who arrive more then 15 minutes late of their scheduled appointment.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowing omitted any information. I give my permission to telephone or email me to discuss matters related to this form. I have had the opportunity to ask questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X ______________________ ______________________

(Signature) Patient / Parent / Guardian (Print Name of Guardian)

DENTIST SIGNATURE: ______________________ DATE: ______________________