

PATIENT'S MEDICAL INFORMATION

FAMILY PHYSICIAN: _____ LOCATION: _____ PHONE # () _____
PHARMACY: _____ LOCATION: _____ PHONE # () _____

HAVE YOU/THE PATIENT:

- Been under the recent care of a physician? YES/NO, Reason: _____
- Had a recent medical check up? WHEN Reason: _____
- Been recently hospitalized? YES/NO, Reason: _____
- Need to be PRE-MEDICATED prior to dental visits? YES/NO Reason & description: _____
- Any other health or other relevant information: _____

DO YOU/THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING (PLEASE CIRCLE):

- | | |
|--|--|
| 1) Chest pain/Heart attack/Stroke/Paralysis | 12) Liver disease/Jaundice/Hepatitis- A/B/C |
| 2) Rheumatic fever/Heart valve defect/Heart murmur | 13) Anemia/ Sickle cell /Trait /Bleeding Disorder/Leukemia |
| 3) Prosthetic heart valve/Pacemaker | 14) Auto-immune disease: _____ |
| 4) Heart disease/Blood pressure- HIGH/LOW | 15) Venereal disease/HIV/AIDS |
| 5) Cough/Cold/Flu/Asthma/Shortness of breath | 16) Kidney disease/Dialysis/Transplant: _____ |
| 6) Bronchitis/Pneumonia/Tuberculosis/Emphysema | 17) Fainting/Panic attacks/Epilepsy |
| 7) Diabetes/Dieting/Weight loss/Thyroid disease | 18) (Women) Pregnancy: Y/N: Month: __, Breast-feeding: Y/N |
| 8) Cancer/Tumors/Growths/Radiation/Chemotherapy | 19) Allergies to: Penicillin/Sulfa/Aspirin /Other: _____ |
| 9) Ear problems/Eye problems | 20) Allergies to: Latex /Artificial Jewelry/Other: _____ |
| 10) Stomach/Intestinal disease | 21) Hereditary/Congenital disorder: _____ |
| 11) Rheumatism/Arthritis/Artificial knee joint | 22) Alcohol/Drug-use/dependency: _____ |

ARE YOU/THE PATIENT CURRENTLY TAKING ANY MEDICATIONS (PLEASE CIRCLE AND WRITE THE NAMES):

- | | |
|--|--|
| • For Blood-pressure/Heart disease/Angina _____ | • Blood-thinner/Aspirin/Antacids _____ |
| • Antibiotics/Anti-diabetics/ Insulin _____ | • Anti-histamines /Steroids /Anti-depressants _____ |
| • Tranquilizers /Painkillers/Anti-epileptics _____ | • Birth-control/Thyroid-supplement/ /Hormone-replacement _____ |
| • Vitamins/Herbal supplements _____ | • Biphosphonates /Other _____ |

PATIENT'S DENTAL INFORMATION

- Reason for today's visit: _____
- Date of last dental visit? ___/___ last X-rays? ___/___ Name of previous dentist: _____
- How often do you/the patient visit the dentist? ___/yr. Brush? ___/day, Floss? ___/day.

DO YOU/THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING (PLEASE CIRCLE):

- Gum bleeding while brushing? YES/NO: Gum Swelling? YES/NO: Bad Breath? YES/NO
- Teeth sensitive to: Cold? YES/NO, Heat? YES/NO, Sweets? YES/NO, Touch? YES/NO
- Adverse reactions to Local anesthetics / Dental Freezing? YES/NO
- Pain in or near your ears? YES/NO, Which side? R/L. Grinding teeth at night / Clenching in daytime? YES/NO
- Jaw-joints hurt or make noise when opening or closing mouth? YES/NO, Side? R/L
- Prolonged bleeding following extractions? YES/NO
- Any growths or sore spots in the mouth? YES/NO, Explain _____
- Smoke or chew tobacco products? YES/NO _____ How much? _____
- Do you/the patient like the way your teeth look? YES/NO, Explain _____

PATIENT CONSENT (Please read carefully and sign below)

I, the undersigned, certify that the above information is correct and consent to performing dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic and /or relative analgesia, on myself/my child/my ward. I agree that I am giving my informed consent to the collection, use and/or disclosure of my personal information to my dental insurer or other medical or dental practitioner for the purposes of dental treatment and/or collection of fees. I understand that if a new purpose arises for the use and/or disclosure of my personal information, your office will seek my approval in advance. I also understand that your office will not, under any circumstances, supply my insurer with confidential medical history. In the event of this request, the office will forward the information directly to me, for review, and specific consent. I am aware that I may withdraw my consent for use of disclosure of my personal information, and will be informed of the ramifications and process of this decision. Regulatory authorities may access my information for legal purposes under Regulated Health Professions Act. I agree that for all legal disputes the jurisdiction of the Province of Ontario will prevail. I have read and understood the above, and agree to assume responsibility for fees charged for the dental treatment performed at every appointment.

DATE _____ PATIENT/GUARDIAN SIGNATURE _____ A/C HOLDER SIGNATURE _____