1. PERSONAL INFORMATION

(MR / MISS / MRS / MS / DR)

NAME: _____ DATE OF BIRTH: _____ /_____ /_____
GIVEN NAME FAMILY NAME DAY MONTH YEAR

ADDRESS (HOME):

_____/ _____/_____/_____/ _____/_____
Street # Street Name Apt/ Suite# City Province Postal Code

PHONE: (HOME): _____(BUSINESS):_____(OTHER):_____

OCCUPATION: _____ EMPLOYER: _____

REFERRED BY:_____

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME OF FAMILY DOCTOR: _____PHONE: _____

NAME OF MEDICAL SPECIALIST: _____ AREA OF SPECIALITY: _____PHONE: _____

2. MEDICAL HISTORY

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 that you do not understand. Please, fill in the entire form.

MEDICAL ALERT CONDITION:_____ PREMEDICATION: _____

1. Have you visited a physician for a medical condition in the past two years? ----------YES /NO
If yes, please explain:_____PHYSICIAN:_____PHONE:_____

2. When was your last visit to a Physician_____ Last complete physical examination? _____

3. Are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? OR have you recently taken any? ----------YES /NO
If yes, please list: _____

4. Have you been hospitalized in the past two years? ----------YES /NO

5. Have you ever reacted adversely to any of the following?

( ) Antibiotics – Penicillin ( ) Sulfonamide ( ) Other Antibiotics ( ) Aspirin
( ) Barbiturates (sleeping pills) ( ) Codeine ( ) Darvon ( ) Local Anaesthetic
( ) Nitrous Oxide ( ) Any other medication, please list _____

6. Have you ever been advised against taking any specific type of medication? YES /NO If yes, please list_____

7. Do you have any of the following?

( ) Asthma ( ) Hay Fever ( ) Food Allergies ( ) Metal or Latex Allergies
( ) Skin Rashes ( ) Hives ( ) Any other allergic condition, please list _____

8. Has any family member had diabetes? ----------YES /NO

9. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? ----------YES /NO

10. Do your ankles, feet or hands swell? ----------YES /NO

11. Has your weight, appetite or energy level changed dramatically recently? ----------YES /NO

12. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ----------YES /NO

13. Do you follow a special diet? ----------YES /NO

14. Have you recently tested HIV positive? ----------YES /NO

15. Do you have FREQUENT SEVERE headaches, earaches, ear or throat infections? ----------YES /NO

16. Have you ever had any injury or surgery to your face or jaws? ----------YES /NO

17. Do you wear eyeglasses or contact lenses? ----------YES /NO

18. Do you have any hearing difficulties? ----------YES /NO

19. Do you smoke or use any other forms of tobacco? ----------YES /NO

Are you wearing the transdermal nicotine patch? ----------YES /NO

20. Are you alcohol and/or drug dependent? ----------YES /NO

Have you received treatment? ----------YES /NO

21. Indicate which of the following you presently have or ever had:

( ) A.I.D.S	( ) Anemia	( ) Angina Pectoris	( ) Arthritis/Rheumatism
( ) Artificial Heart Valve	( ) Artificial Joints	( ) Blood Disorders	( ) Bronchitis
( ) Cancer	( ) Circulation Problems	( ) Congenital Heart Lesions	
( ) Cortisone/ Steroid	( ) Diabetes	( ) Emphysema	( ) Epilepsy or Seizures
( ) Fainting or Dizzy Spells	( ) Glandular Disorders	( ) Glaucoma	( ) Head/ Neck Injuries
( ) Heart Disease or Attack	( ) Heart Murmur	( ) Heart Pacemaker	( ) Heart Rhythm Disorder
( ) Heart Surgery	( ) Hepatitis A	( ) Hepatitis B	( ) Hepatitis C
( ) Herpes	( ) High/ Low Blood Pressure		( ) Hodgkins Disease
( ) Hyper(Hypo) Glycemia	( ) Hypertension	( ) Jaundice	( ) Kidney disease
( ) Liver Disease	( ) Lung Disease	( ) Malignant Hyperthermia	
( ) Mental/nervous Disorder	( ) Mitral Valve Prolapse	( ) Organ Transplant/ Medical Transplant	
( ) Psychiatric Treatment	( ) Radiation Treatment/ Chemotherapy		( ) Rheumatic/ Scarlet Fever
( ) Sickle Cell Disease	( ) Sinus Trouble	( ) Stomach/ Intestinal Problem	
( ) Stroke	( ) Thyroid Disease	( ) Tuberculosis	( ) Ulcers
( ) Vernereal Disease	( ) Other _____		

22. Has the CHILD PATIENT recently had any of the following (indicate approximate date)?

( ) Measles ( ) Mumps ( ) Chicken Pox ( )Strep Throat ( ) Tonsillitis

23. WOMEN ONLY: Are you pregnant or suspect you might be? ----------YES /NO

If yes, what is the expected birth date? _____ Are you taking any birth control pills ----------YES /NO

24. Do you currently have, or have you had in the past, any disease, condition, or problem not listed above? ----------YES /NO

If yes, please list _____

25. Is there anything else about your health we should be made aware of? _____

26. Are you nervous during dental treatment? ----------YES /NO

27. Do you wish to speak to the Doctor privately about any problem or medical condition? ----------YES /NO

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE:_____**DATE:** _____

DENTIST SIGNATURE: _____**DATE:** _____