

Medical Alert

Patient Information Form

Patient I.D.#

Parent or Guardian will be responsible for decisions relating to my treatment: Yes No

Name:

First

Initial

Last

Address:

Street

Apt.# City

Prov. Postal Code

D.O.B.

Home Tel:

Work Tel:

Referring Dr.

Tel:

Family Dr.

Tel:

Specialist Dr.

Tel:

Emergency Contact

Tel:

Driver's Licence

or

S.I.N.

Method of Payment: Cash/Debit Cheque Credit Card Insurance Other

Financial Contact: Self Spouse Parent Other Please fill out if different than above

Name:

First

Initial

Last

Address:

Street

Apt.# City

Prov. Postal Code

D.O.B.

Home Tel:

Work Tel:

Primary Insurance Company:

Tel:

Employer/Group Policy Holder:

Year End:

Policy #:

Certificate #:

ID/SIN #:

Max. Coverage:

% **Coverage for:** Basic

Major Restorative

Orthodontist

Secondary Insurance Company:

Tel:

Employer/Group Policy Holder:

Year End:

Policy #:

Certificate #:

ID/SIN #:

Max. Coverage:

% **Coverage for:** Basic

Major Restorative

Orthodontist

Medical History (this information will remain confidential)

Yes No

1. Are you presently under the care of a physician? _____
2. Have you ever had a serious illness or been hospitalized? _____
3. Are you currently taking any drugs or medications? _____
4. Have you ever had an adverse effect to: Aspirin, Sleeping Pills, Antibiotics(Penicillin, Sulfonamide, Other), Codeine, Darvon _____
5. Have you ever been warned against taking other medications? _____
6. Have you ever used medical or non-medical drugs? _____
7. Do you suffer from any allergies (hay fever, latex. etc..)? _____
8. Do you smoke? _____
9. Have you ever fainted, had shortness of breath or chest pains? _____
10. **Women:** Are You Pregnant? Y N Have you reached menopause? Y N Are you taking birth control? _____
11. Do you have or have you ever had any of the following:

A.I.D.S.	Cancer	Heart disease/attack	Jaundice	Rheumatic/Scarlet fever
Anemia	Circulation problems	Heart murmur	Kidney disease	Sickle cell disease
Angina pectoris	Congenital heart lesions	Heart pacemaker/surgery	Liver disease	Sinus trouble
Anorexia nervosa	Cortisone/steriod	Heart rhythm disorder	Leukemia	Stomach/intestinal prob.
Arthritis/rheumatism	Diabetes	Hepatitis A/B/C	Lung disease	Stroke
Artificial heart valve	Drug/Alcohol dependence	Herpes	Malignant hyperthermia	Thyroid disease
Artificial joints (hip, knee)	Emphysema	High/Low blood pressure	Mental/nervous disorder	Tuberculosis
Asthma	Epilepsy or seizures	H.I.V. positive	Mitral valve prolapse	Ulcers
Blood disorders	Glaucoma	Hodgkins disease	Organ transplant/implant	Veneral disease
Bronchitis	Glaucoma	Hyper (Hypo) glycemia	Psychiatric treatment	Other
Bulimia	Head/neck injuries	Hypertension	Radiation/Chemotherapy	None

Children Only: Have you recently had any of the following:

Chicken Pox	Measles	Mumps	Strep Throat	Tonsillitis
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Dental History

1. What is the reason for today's visit? Examination Emergency Other
 2. How often do you see a dentist? Every _____ month(s) When was your last dental visit? _____ Last X-Ray? _____
 3. How often do you brush? _____ Floss? _____ Use Antibacterial rince? _____
 4. Are your teeth sensitive to: Cold Sweets Heat Other
 5. Do your gums bleed when: Brushing Flossing Never
 6. Do you gums feel swollen or tender? _____
 7. Do you have bad breath or a bad taste in your mouth? _____
 8. Do your jaws crack, pop or grate when you open widely? _____
 9. Do you grind or clench your teeth? _____
 10. Do you have food catch between your teeth? _____
 11. Have you ever had local anaesthetic (freezing)? _____
 12. Have you ever had complications due to local anaesthetic? _____
 13. Have you ever had any of the following treatments? _____
- | | | | | | | |
|----------------|--------------------------|--------------------|------------|----------------------|------------|------|
| Crowns or Caps | Full or Partial Dentures | Periodontal (Gums) | Bridgework | Orthodontic (braces) | Root Canal | None |
|----------------|--------------------------|--------------------|------------|----------------------|------------|------|
14. Are you satisfied with the appearance of your teeth? _____

Yes No

General Release I, the undersigned, understand that the data contained in the dental and medical history portion of this chart is important to my treatment. I certify that all the information is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health provider as is required by Health Centre Dental Office. I authorize Health Centre Dental Office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature

Print Name

Date