DENTISTRY IN BOLTON
MEDICAL AND DENTAL INFORMATION

DATE: _____

1. General Information Male ☐ Female ☐
Adult ☐ Child ☐

Name: _____ Mr ☐ Mrs ☐ Dr ☐ Ms ☐
(First) (Middle) (last)

Address: _____
City: _____ Province _____ Postal Code _____
Email: _____@_____
Date of Birth _____/_____/_____ Age: _____ Marital Status _____
M D Y
Home#: _____ Cell #: _____ Business #: _____

Occupation: _____ Employer: _____
Dental Insurance coverage: _____ ID# _____
Insurance Holder for the Account _____ Group# _____

Medical Office:
Family Physician: _____ Phone# _____
Medical Specialist: _____ Phone# _____

In case of Emergency:
Please notify: _____ Relationship: _____
Home# _____ Other Phone: _____

Who may we thank for referring you to our office? _____

---

2. Medical History

1. Date of your last physical examination. _____
2. Are you presently under the care of a physician? _____
3. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? _____
4. Has there been any change in you general health in the past year?
   If yes, please explain _____
5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes please list _____
6. Have you taken any medication for an extended period of time in the past? _____
7. Do you smoke or chew tobacco products? _____
8. Do you have any food or environmental allergies? _____ other? _____
9. Do you have any allergies to medications? _____
10. Have you ever had a peculiar or adverse reaction to injections of local anesthetics? If yes, please explain. _____
11. Have you ever had pain in your chest or shortness of breath? _____
12. Do you have or have you ever had asthma? ____ If yes do you have an inhaler _____ Type _____
13. Do you have or have you ever had heart or blood pressure problems? _____
14. Do you have or have you ever had heart murmur, mitral valve prolapse or rheumatic fever? _____
15. Do you have a prosthetic or artificial joint? _____ If yes, when was it placed? _____
16. Have you ever required antibiotics before any dental procedure? _____
17. Have you ever been advised by your Doctor to take antibiotics before dental treatment? _____ Reason? _____
18. Do you have any conditions that could affect your immune system, eg. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? _____
19. Have you ever had hepatitis, jaundice or liver disease? _____
20. Have you ever had tonsillitis? _____

21. Do you have a bleeding problem or bleeding disorder or any problem with healing? _____
22. Have you ever been hospitalized for any illness or operations or any type of surgery? If yes, please explain. _____
23. Do you have or ever had any of the following? Please check.

Chest Pain/Angina	Nervous Problems	Artificial Joints
Heart Attack	Psychiatric care	Diabetes
Stroke	Kidney Disease	Arthritis
Rheumatic Fever	Liver Disease	Gout
Mitral Valve Prolaspe	Sinus Problems	Anemia
Artificial Heart Valve	Thyroid Disease	Asthma
Heart Surgery	Veneral Disease	Lung Disease
Pacemaker	Stomach Ulcers	Epilepsy
High Cholesterol	Digestive Disorders (Acid Reflex)	Cancer
High Blood Pressure	Bowel Disorder	Radiation Treatment
Low Blood Pressure	Tuberculosis	Chemotherapy
Fainting Spells	Hepatitis	Glaucoma
Multiple Sclerosis	AIDS/HIV	Auto Immune Disease
Muscular Distrophy	Blood Disorder	Alcoholism/Drug Addiction

24. Are the any conditions or diseases not listed above that you have or have had? _____
25. Are there any diseases or medical problems that run in your family? (eg. Diabetes, cancer or heart disease) _____
26. Women Only: Are you pregnant? _____Nursing? _____Menopause? _____Birth Control Pills? _____

---

3. Dental History

1. Are you having any discomfort at this time? _____
2. How long since your last dental visit? _____
3. What was done at that time? _____
4. Do your gums bleed when brushing? _____
5. Does food wedge between your teeth? _____
6. Have you ever been given local anesthetic (freezing)? _____
7. Do you have any pain in or around your ears? _____
8. Do you grind or clench your teeth? _____
9. Are you aware of any lump or swelling in your mouth? _____
10. Are you aware of any unpleasant taste in your mouth? _____
11. Are you satisfied with the appearance of your teeth? _____
    What would you like changed if you could? _____
12. Do you have dry mouth? _____
13. Have you ever thought of whitening opportunities? _____

Update

1. Date _____ Change _____
2. Date _____ Change _____
3. Date _____ Change _____
4. Date _____ Change _____
5. Date _____ Change _____
6. Date _____ Change _____

Office Policy

1. Please help us to maintain the operation of our office on sound principles so that we may assure you and other patients
2. have uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore at least 48 hours NOTICE must be given if cancellation is absolutely necessary. A fee may apply.
3. Office policy is that services are paid for each visit as they are performed. However, in certain circumstances arrangements for payment may be made by consulting the Doctor.
4. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE PATIENT AND PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THEIR ACCOUNTS. We will prepare any necessary forms for reports to help collect your benefits from insurance companies

Patient's Signature _____