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 used medical or non-medical drugs for a prolonged period?	☐	☐
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	☐ Glandular disorder	☐ Hodgkins disease	☐ Organ transplant/implant	☐ Venereal 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

Dental History

1. What is the reason for today's visit? ☐ Examination ☐ Emergency ☐ Other
2. How oftern do you see a dentist? Every ☐ month(s). When was your last dental visit? _____ Last X-Ray? _____
3. How often do you brush? ----Select---- Floss? ----Select---- Use Antibacterial rince? ----Select----
4. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other

	Yes	No
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 anaesthic?	☐	☐

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? ☐ ☐

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 _____