smilee DENTAL CENTRE

Medical History

Name_____

Date of Birth (D/M/Y) _____

Address_____

City_____Postal Code_____

Home Phone_____

Cell Phone _____

Work Phone_____

E-mail_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name_____

Relationship_____

Primary Phone_____

Alternate Phone_____

How did you hear about us? Referral ☐ Website ☐ Direct Mail ☐ Previous patient ☐ _____

Names/Phone of Family Doctor and Medical Specialists

_____ _____
Family Doctor Phone

_____ _____
Specialist Phone

_____ _____
Pharmacy Phone

When was your last medical check up? _____

Are you being treated for any medical condition at present or have you been treated within the past year? If yes Why?

_____

Please list all your drug allergies

_____

Do you have a latex allergy? Yes ☐ No ☐

Any other allergies _____

Current Medications **(Please list ALL <u>medications</u> AND <u>dosages</u> that you take, including vitamins & herbal supplements)**

_____

_____

_____

Has a dentist or physician ever told you that you need to take antibiotics before having dental treatment? Yes ☐ No ☐

Have you ever been hospitalized? Yes ☐ No ☐

If yes, for what _____

Do you smoke? Yes ☐ No ☐ If YES, Cigarettes ☐ Cigars ☐ Chew tobacco ☐ Vapor/E-Cig ☐ Marijuana ☐

For how many years? _____ How many packages/day? _____

Are you nervous during dental treatment? Yes ☐ No ☐ How nervous? 1 2 3 4 5 6 7 8 9 10

DO YOU HAVE, OR HAVE YOU BEEN INFORMED THAT YOU HAVE ANY OF THE FOLLOWING:

If YES, please specify condition and explain

Heart Condition Yes ☐ No ☐

Heart Murmur/Mitro Valve Prolapse/Heart Attack

Stroke/Angina/Stent/Congestive Heart Failure

Congenital heart defect/Pace maker/Rheumatic Fever

Blood Pressure Yes ☐ No ☐

High or Low

Respiratory Problems Yes ☐ No ☐

Asthma/Tuberculosis/Emphysema

Other _____

Sinus Trouble Yes ☐ No ☐

Cold Sores/Herpes Yes ☐ No ☐

Thyroid Problems Yes ☐ No ☐

Hypothyroid/Hyperthyroid

Diabetes Yes ☐ No ☐

Stomach or Intestinal Disease Yes ☐ No ☐

Organ Transplant Yes ☐ No ☐

If YES, which organ and when?

_____

Artificial Joint Replacement Yes ☐ No ☐

If YES, Which joint and when ?_____

Name of Orthopaedic surgeon _____

Epilepsy/Seizures/Fainting Yes ☐ No ☐

Glaucoma or Eye Problems Yes ☐ No ☐

Liver Disease Yes ☐ No ☐

Jaundice/Hep A/Hep B/Hep C Yes ☐ No ☐

Cancer Yes ☐ No ☐

If YES, type and when diagnosed?

_____

Chemotherapy or Radiotherapy Yes ☐ No ☐

Alcoholism or Drug Addiction Yes ☐ No ☐

AIDS or HIV Yes ☐ No ☐

STD's or STI's _____

Hormonal Imbalance Yes ☐ No ☐

Kidney Problems or Dialysis Yes ☐ No ☐

Abnormal bleeding/Blood disorder Yes ☐ No ☐

Hemophilia/Anemia

Psychiatric/Mental Health Conditions Yes ☐ No ☐

If YES, please specify ?_____

Arthritis or Inflammatory Conditions Yes ☐ No ☐

Women: Are you pregnant/breast feeding? Yes ☐ No ☐

Taking hormone replacement Yes ☐ No ☐

Do you have or have you had any other condition not mentioned

_____

I understand that the dental provider may use my health information for treatment, payment and health care operations. Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law. This office will collect, use and disclose information about you:

- to communicate with other treating health-care providers, including specialists and general dentists who are referring dentists and/or peripheral dentists
- to allow us to efficiently follow-up for treatment, care and billing
- to complete and submit dental claims for third party adjudication and payment

If I have dental insurance, I authorize my insurance carrier to be billed for any services provided. I understand that this treatment may affect my future rights and benefits under my dental insurance. Regardless of whether or not I have dental insurance, I understand that I am responsible for paying the dental provider for all services that are charged to me.

X _____
(Patient/Legal Representative Signature)

X _____
Relationship to Patient (If under 18)

Date _____

Dentist Signature _____