MEDICAL DENTAL HISTORY FORM - ADULT

Please fill out the form below

MEDICAL/DENTAL HISTORY FORM - ADULT

Last Name | Initial | First Name

Address | City | Postal

Home Tel | Cell | Work

Date of Birth: DD/MM/YYYY | Email Address

Emergency Contact | Phone

How did you hear about us? | Health Card #

Do you have dental insurance? Yes No If Yes complete the following

Primary Insurance

Company | Policy Holder

Policy/Plan/Group | Certificate/I.D.

Policy holders Date of Birth DD/MM/YYYY | Relation to Holder

Secondary Insurance

Company | Policy Holder

Policy/Plan/Group | Certificate/I.D.

Policy holders Date of Birth DD/MM/YYYY | Relation to Holder

Has there been any change in your general health? Yes No

If YES please describe

Are you being treated for any medical condition or have you been treated within the past 2 years? Yes No

If YES please describe

Are you currently being treated by a physician for a specific condition? Yes No

If YES please describe

Are your currently taking any medication? Yes No

Medication | Dose

Medication | Dose

Medication | Dose

Do you bleed or bruise easily? Yes No

Have you ever been hospitalized? Yes No

If YES please describe

Have you ever received general anesthesia? Yes No

Have you ever had an adverse reaction to local anesthetic? Yes No

Do you have any allergies to medications? Yes No

If YES please describe

Do you have any other allergies?

Yes No

If YES please list

Do you currently have any of the following conditions?

Heart Murmur	Osteoporosis	Osteopenia	Rheumatic Fever	Asthma	COPD
Sleep Apnea	Hepatitis A/B/C/D	Thyroid Disease	Mental Illness	AIDS/HIV	Herpes / Cold Sores
Emotional Problems	Heart Attack	Angina	Glaucoma	Atherosclerosis	Stroke
Kidney Disease	Liver Disease	Kidney Disease	Kidney Disease	Drug/Alcohol Abuse	Cancer
Jaundice	ADHD	Epilepsy	Pacemaker	Organ Transplant	Arthritis
Radiation Therapy	Steroid Therapy	Stress	Diabetes Type 1 / Type2	Steroid Therapy	Surgery to Head and Neck

Is there anything else the doctor needs to know regarding your medical health? Yes No

If YES please explain

Do you smoke? Yes No Quit Tobacco Cigars Chew Other

Amount/day | for how long? | Quit Date

Females ONLY

Are you or could you be pregnant? Yes No

Are you currently breast-feeding ? Yes No

Dental History

Are you currently experiencing any pain or discomfort? Yes No

Are any of your teeth sensitive to Cold Hot Sweet Biting

Do you have difficulty chewing food or does food get stuck between your teeth? Yes No

Are you unhappy with the overall appearance of your teeth? Yes No

Have you ever had braces for straightening your teeth? Yes No

Have you ever had an injury to your jaw or face? Yes No

Does your jaw ever click or pop or cause pain upon opening or closing? Yes No

Are you nervous during dental treatment? Yes No

Reason

PATIENT CERTIFICATION AND CONSENT

I the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and determination of benefits. Unless other arrangements have been made assignment of benefits from your insurance company will be set up. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and my dentist. I authorize the dentist to treat me and I assume full responsibility for all fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

_____ SIGNATURE (PARENT OR GUARDIAN IF UNDER 16)

To be signed at your appointment