PATIENT INFORMATION

DATE: \ \ (M D Y)

PATIENT IS AN: ADULT☐ CHILD☐ ADULT UNDER GUARDIANSHIP ☐ **NAME OF GUARDIAN:**

Name _____ (last) (first) (initial) Nickname _____ Mrs.☐ Ms☐ Mr.☐

Home Address _____ (street) (city) (prov.) (postal code)

Home Phone ( ) _____ Cellular Phone ( ) _____ Fax # ( ) _____

Date of Birth: \ \ (M D Y) Age: _____ Sex: _____ Marital Status: _____

Driver's License # _____ email: _____

Family Physician: _____ Phone: ( ) _____

Medical Specialist (if presently under care) Phone: ( ) _____

OCCUPATION:

Employed By: _____ Phone ( ) _____ Ext. _____

Spouse Employed By: Phone ( ) Ext.

DENTAL INSURANCE Yes☐ No☐ Group Policy # _____ Certif. # _____

Primary Insurance Co. Name: Yr. End

Coverage: Basic %	Prosthetics %	Crown/Bridge %	Ortho %	Perio Scaling %

Secondary Ins Co Name _____ Group Pol # Certif.# Yr. End

Coverage: Basic %	Prosthetics %	Crown/Bridge %	Ortho %	Perio Scaling %

PERSON RESPONSIBLE FOR ACCOUNT Self☐ Other☐ → Name: _____

Address _____

Home Phone ( ) Business Phone ( )

IN CASE OF EMERGENCY Please Notify _____ Relationship _____

Home Phone: ( ) _____ Business Phone: ( ) _____ Ext. _____

Is any other member of your family or relative a patient at our office?

REASON FOR TODAY'S VISIT Examination☐ Emergency☐ Other☐ _____

Who may we thank for referring you to our office?

MEDICAL HISTORY — **PLEASE CHECK YES OR NO. *IF NOT SURE*, CHECK NS.**	NO	NS	YES	
Are you presently under Doctor's care? Why?				
Have you been under Doctor's care in the past two years? Why?				
Have you taken any medications, pills or drugs in the past two years?				
Are you presently taking any medications, pills or drugs?				⇨ **If YES, list them here:**
Are you presently taking any Natural Supplements? e.g., Vitamins or Herbs				⇨
Have you ever had Tonsillitis?				
Have you been hospitalized in the past two years? (If yes, why?)				
Have you had any type of surgery? What & When?				
When was your last complete physical examination?				
When walking, do you ever have to stop because of pain in your chest or shortness of breath?				
Are you on a prescription diet?				
Have you ever been diagnosed as having a tumor or cancer?				
Have you ever taken cortisone/steroid medication?				
Do you experience problems with healing?				
Do you wish to speak privately with the Doctor about any problem?				
Do you smoke? (If yes, how much?)				
Are you currently in good health?				
Do you bruise easily or bleed excessively?				
Have you ever been warned about anaesthetic risks?				

SHADED AREAS - OFFICE USE ONLY

MEDICAL HISTORY

MEDICAL ALERT	CONDITION	PREMEDICATION	ALLERGIES	ANAEST.

ALLERGIES	Please check off any medications you are allergic to or you have reacted adversely to:				
☐ Ibuprofen (Advil)	☐ Nembutal	☐ Demerol	☐ Ampicillin	☐ Rovamycin	☐ Local Anaesthic (Freezing)
☐ Aspirin	☐ Seconal	☐ Percodan	☐ Erythromycin	☐ Cephalexin	☐ Nitrous Oxide
☐ Tylenol	☐ Naproxen	☐ Darvon	☐ Clindamycin	☐ Sulpha Drugs	☐ Amoxicillin
☐ Tylenol #2, #3, #4	☐ Toradol	☐ Penicillin	☐ Scopolamine	☐ Metal	☐ Chlorhexidene (Peridex)
☐ 222, 282, 292	☐ Codeine	☐ Valium	☐ Tetracycline	☐ Latex	☐ Bandage

☐ **Food Allergies, please list:**

Please list any other medications or substances which you know you are allergic to:

MEDICAL CONDITIONS	Please check off all of the following conditions you presently have, or have had. (If not sure, check off NS)											
	No	NS	Yes		No	NS	Yes		No	NS	Yes	
Malignant Hyperthermia				Scarlet Fever				Rheumatic Fever				
Stomach/Intestinal Problems				Kidney Trouble				Artificial Joints/Hips				
Transdermal Nicotine Patches				Ulcers				Diabetes or Hypoglycemia				
High Blood Pressure\Hypertension				Asthma				Arthritis/Rheumatism				
Low Blood Pressure				Hay Fever				Epilepsy or Seizures				
Heart Failure				Sinus Trouble				Glandular Disorders				
Congenital Heart Lesion				Emphysema				Psychiatric Care				
Artificial Heart Valve				Frequent Cough				Mental/Nervous Disorders				
Heart Pacemaker				Lung Disease				AIDS(HIV Positive)				
Heart Surgery				Bronchitis				Venereal Disease				
Heart Murmur				Tuberculosis				Herpes				
Mitral Valve Prolapse				Liver Disease				Cold Sores				
Chest Pain				Hepatitis A (infec.)				Fever Blisters				
Angina Pectoris				Hepatitis B (serum)				Blood Disorders				
Shortness of Breath				Hepatitis C				Circulation Problems				
Stroke				Yellow Jaundice				Sickle Cell Anemia				
Fainting or Dizziness				Thyroid Disease				Hemophilia				
Anemia				Glaucoma				Cancer				
Cardiac Arrest/ Heart Attack				Pain in Jaw Joints				Chemotherapy/Radiation				
Swelling of Feet/Ankles/Hands				Head/Neck Injuries				X-Ray/Cobalt Treatment				
Drug or Alcohol Addiction				If Yes, have you received treatment? Where?								

Is there anything we have not mentioned that you think we should know regarding your medical history?

WOMEN ONLY		
	Are you pregnant? Yes☐ No☐	Are you taking Birth Control Pills? Yes☐ No☐
	Are you nursing? Yes☐ No☐	Are you taking Fertility drugs? Yes☐ No☐

Follow-up information to above questions: