DENTISTRY ON 7th

Medical Alert	Date M D Y

Mr. Mrs. Miss Ms. Last Name	First	Initial	Gender Male Female	Date of Birth M D Y
Address	City/Prov.			Postal Code
Residence Phone #	Work Phone #		Cell Phone #	
Email Address	Preferred Method of Contact (circle one) Phone Email Text Message			
How did you hear about us?	Emergency Contact name		Telephone	

Primary Insurance

Name of Insured		Date of Birth M D Y
Employer		
Insurance Provider		
Group / Policy #	Division	
ID / Certificate #	SIN #	

Secondary Insurance

Name of Insured		Date of Birth M D Y
Employer		
Insurance Provider		
Group / Policy #	Division	
ID / Certificate #	SIN #	

Medical History

		(circle one)	
1	Are you presently under the care of a Physician?	Yes	No
2	Have you been hospitalized in the past 2 years?	Yes	No
3	Are you taking any drugs or medications?	Yes	No
	a. Drug _____		
	b. Drug _____		
	c. Drug _____		
4	Have you ever had any allergies to any medication?	Yes	No
	Which _____		
5	Have you ever been warned against using any medication?	Yes	No
	Which _____		
6	Do you suffer from any non-drug related allergies?	Yes	No
	Which _____		
7	Are you allergic to latex?	Yes	No
8	Do you bruise easily or have prolonged bleeding?	Yes	No
9	Do you smoke? How many per day? _____	Yes	No
10	Do you have shortness of breath?	Yes	No
11	Have you ever had chest pains?	Yes	No
12	Have you ever been advised to take antibiotics before a Dental treatment?	Yes	No

Women

13	Are you pregnant? If so, Due Date: _____	Yes	No
14	Have you reached Menopause?	Yes	No
15	Are you using Birth Control	Yes	No

Do you have, or have you ever had, any of the following? (please circle)

16-A.I.D.S	35-Glandular disorders	54-Leukemia
17-Anemia	36-Glaucoma	55-Lung disease
18-Angina	37-Head/neck injuries	56-Malignant hypothermia
19-Anorexia Nervosa	38-Heart disease/Attack	57-Mental/nervous disorder
20-Arthritis/Rheumatism	39-Heart murmur	58-Migraine headaches
21-Artificial Heart Valve	40-Heart pacemaker/surgery	59-Mitral valve prolapse
22-Artificial joint(s)	41-Heart rhythm disorder	60-Organ transplant/implant
23-Asthma	42-Hepatitis A	61-Psychiatric treatment
24-Blood disorder	43-Hepatitis B	62-Radiation/chemotherapy
25-Bronchitis	44-Hepatitis C	63-Recurring headaches
26-Bulimia	45-Herpes	64-Rheumatic or scarlet fever
27-Cancer	46-High/Low Blood pressure	65-Sickle cell disease
28-Circulation problems	47-H.I.V Positive	66-Sinus trouble
29-Congenital heart lesions	48-Hodgkin's disease	67-Stomach/intestinal probs.
30-Cortisone/steroid treatment	49-Hyper/Hypo Glycemia	68-Stroke
31-Diabetes	50-Hypertension	69-Thyroid disease
32-Drug/alcohol dependence	51-Jaundice	70-Tuberculosis
33-Emphysema	52-Kidney disease	71-Venereal disease
34-Epilepsy/Seizures	53-liver disease	Other _____

Children

Have you recently had any of the following?

72	Chicken Pox - Date: _____	Yes	No
73	Measles - Date: _____	Yes	No
74	Mumps - Date: _____	Yes	No
75	Strep throat - Date: _____	Yes	No
76	Tonsillitis - Date: _____	Yes	No

Please Turn to 2nd page

Dental History

What is the reason for today's visit? _____

How frequently do you see a dentist? _____

When was your last dental visit? _____ Dentist? _____

How often do you brush per day? _____ Floss? _____

Are your teeth sensitive to: __ Cold __ Sweets __ Heat __ Other

Do your gums bleed when: __ Brushing __ Flossing __ Never

Do your gums feel swollen or tender?	Yes	No
Do you have bad breath or a bad taste in your mouth?	Yes	No
Do your jaws crack, pop or grate when you open widely?	Yes	No
Do you experience recurring headaches or migraines?	Yes	No
Do you grind or clench your teeth?	Yes	No
Does food ever catch between your teeth?	Yes	No
Have you ever had local anesthetic? (freezing)	Yes	No
Any complications? Specify _____	Yes	No
Have you ever had any problems with previous dental treatment? Specify _____	Yes	No

Have you ever had any of the following?

__ Bridgework __ Crowns/Caps __ Full/Partial Dentures
__ Orthodontic (braces) __ Periodontal (gums) __ Root Canal

Do you snore? Any family history of Sleep apnea? Yes No

Rate your smile from 1 to 10 (1 = very unsatisfied, 10 = very satisfied)

☹ 1 2 3 4 5 😐 6 7 8 9 10 ☺

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct to the best of my knowledge and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I authorize electronic submission of benefits claims on my behalf to my insurance carrier.

Missed appointments or cancellations with less than 2 business days notice will be billed $50

Patient/Parent/Guardian _____ Date: _____
Signature Print Name

Doctor _____ Date: _____
Signature Print name