

# Welcome to our Dental Office

**Medical Alert** 

WEB-BASED FORM

Mr.  Mrs.  Ms.  Miss  Dr.    The patient is an **Adult**  **Child**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Initial) \_\_\_\_\_ Prefer to be called: \_\_\_\_\_

Address: (Street) \_\_\_\_\_ (Apt.#) \_\_\_\_\_ (City) \_\_\_\_\_ (Postal Code) \_\_\_\_\_

Home ☎: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work ☎: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other ☎: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Male  Female

Employer / School: \_\_\_\_\_ Occupation: \_\_\_\_\_

eMail: \_\_\_\_\_ Whom may we thank for referring you to this office?: \_\_\_\_\_

Are you likely to be available on short notice for future appointments or appointment changes?  Yes  No

Family Physician: \_\_\_\_\_ ☎ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Relation: \_\_\_\_\_ ☎ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Person responsible for this account:  Self  Spouse  Parent  Legal Guardian  Other

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Initial) \_\_\_\_\_ Relation: \_\_\_\_\_

Address: (Street) \_\_\_\_\_ (Apt.#) \_\_\_\_\_ (City) \_\_\_\_\_ (Postal Code) \_\_\_\_\_

Home ☎ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work ☎ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Method of Payment  Cash  Cheque  Debit  Credit Card

PRIMARY INSURANCE	SECONDARY INSURANCE
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Subscriber: _____	Subscriber: _____
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Relation: <input type="checkbox"/> Self <input type="checkbox"/> Spouse Other: _____	Relation: <input type="checkbox"/> Self <input type="checkbox"/> Spouse Other: _____
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Insurance Co: _____	Insurance Co: _____
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Policy/Plan #: _____ Division/Sect. #: _____	Policy/Plan #: _____ Division/Sect. #: _____
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Subscriber I.D. or SIN #: _____	Subscriber I.D. or SIN #: _____
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MEDICAL HISTORY Please <input checked="" type="checkbox"/> YES or NO to each question.	All information is confidential	
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The following information is required by the dentist to assist in proper diagnosis and treatment. **YES** **NO**

- |  |   |   |
|--|---|---|
| 1. Have you ever had a serious illness requiring hospitalization or extensive medical care? . . . . .  | ☐ | ☐ |
| Please specify: _____  |   |   |
| 2. Are you presently under the care of a physician? . . . . .  | ☐ | ☐ |
| If so, please explain: _____   |   |   |
| 3. Have you had a medical examination in the last year? . . . . .  | ☐ | ☐ |
| 4. Do you use any prescription or non-prescription drugs regularly? . . . . .  | ☐ | ☐ |
| Please specify: _____  |   |   |
| 5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? . . . . .   | ☐ | ☐ |
| 6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? . . . . .   | ☐ | ☐ |
| Please specify: _____  |   |   |
| 7. Have you been hospitalized in the last 5 years? . . . . .   | ☐ | ☐ |
| Please specify: _____  |   |   |
| 8. Have you ever experienced any unusual reaction to any of the following? (Please circle) . . . . .   | ☐ | ☐ |
| local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or<br>or any other medicine? If so please explain _____ |   |   |
| 9. Have you been warned against taking any drug or medication? . . . . .   | ☐ | ☐ |
| 10. Do you bruise easily or bleed abnormally? . . . . .  | ☐ | ☐ |

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**MEDICAL HISTORY (Cont'd)** Please  **YES** or **NO** to each question.

- |   |   |  |   |   |                                    |
|---|---|--|---|---|------------------------------------|
| <p>11. Have you ever had any organ implants or medical implants? .....</p> <p>12. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? .....</p> <p>13. Do you have frequent headaches? .....</p> <p>14. Do you have A.I.D.S. or have you ever tested positive for H.I.V.? .....</p> <p>15. Do you have or ever had any of the following? .....</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Heart murmur or Mitral Valve Prolapse<br/> <input type="checkbox"/> Stomach /Intestinal Problems<br/> <input type="checkbox"/> Joint Replacement (hip, knee, etc.)<br/> <input type="checkbox"/> Mental or Nervous Disorder<br/> <input type="checkbox"/> High/low Blood Pressure<br/> <input type="checkbox"/> Hyper (hypo) Glycemia<br/> <input type="checkbox"/> Epilepsy or Seizures<br/> <input type="checkbox"/> Cortisone/Steroid Therapy                 </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Malignant Hyperthermia<br/> <input type="checkbox"/> Drug / Alcohol Dependency<br/> <input type="checkbox"/> Venereal Disease<br/> <input type="checkbox"/> Lung Disease (i.e. Asthma)<br/> <input type="checkbox"/> Thyroid Disease<br/> <input type="checkbox"/> Arthritis or Rheumatism<br/> <input type="checkbox"/> Scarlet or Rheumatic Fever<br/> <input type="checkbox"/> Cancer / Chemotherapy                 </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Liver Disease<br/> <input type="checkbox"/> Heart Attack<br/> <input type="checkbox"/> Cold Sores<br/> <input type="checkbox"/> Jaundice<br/> <input type="checkbox"/> Diabetes<br/> <input type="checkbox"/> Tuberculosis<br/> <input type="checkbox"/> Hepatitis A,B, C<br/> <input type="checkbox"/> Other: _____                 </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Herpes<br/> <input type="checkbox"/> Sinus Trouble<br/> <input type="checkbox"/> Stroke<br/> <input type="checkbox"/> Kidney problems<br/> <input type="checkbox"/> Emphysema<br/> <input type="checkbox"/> Glaucoma                 </td> </tr> </table> | <input type="checkbox"/> Heart murmur or Mitral Valve Prolapse<br><input type="checkbox"/> Stomach /Intestinal Problems<br><input type="checkbox"/> Joint Replacement (hip, knee, etc.)<br><input type="checkbox"/> Mental or Nervous Disorder<br><input type="checkbox"/> High/low Blood Pressure<br><input type="checkbox"/> Hyper (hypo) Glycemia<br><input type="checkbox"/> Epilepsy or Seizures<br><input type="checkbox"/> Cortisone/Steroid Therapy | <input type="checkbox"/> Malignant Hyperthermia<br><input type="checkbox"/> Drug / Alcohol Dependency<br><input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> Lung Disease (i.e. Asthma)<br><input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> Arthritis or Rheumatism<br><input type="checkbox"/> Scarlet or Rheumatic Fever<br><input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Heart Attack<br><input type="checkbox"/> Cold Sores<br><input type="checkbox"/> Jaundice<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Hepatitis A,B, C<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Herpes<br><input type="checkbox"/> Sinus Trouble<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Kidney problems<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Glaucoma | <p><b>YES</b></p> <p><b>NO</b></p> |
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16. Have you had any injury, surgery or x-ray therapy to your face or jaws? .....
17. Do you have any disease, condition, or problem that you think the doctor should know about? .....
18. WOMEN ONLY: Are you pregnant or suspect you might be? If so, what month are you in? \_\_\_\_\_
- Are you taking birth control pills? .....

**DENTAL HISTORY** Please  **YES** or **NO** to each question.

- |  |            |           |
|--|------------|-----------|
|  | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|
1. Reason for today's visit:  Exam  Cleaning  Emergency  Other \_\_\_\_\_
- Are your presently having dental pain? .....
- Is there a dental problem you would like to take care of as soon as possible? .....
2. How frequently do you see your dentist?  3 months  6 months  Yearly  Other \_\_\_\_\_
- Previous Dentist: \_\_\_\_\_ Last dental visit: \_\_\_\_\_
- Last cleaning: \_\_\_\_\_ Full mouth series of x-rays: \_\_\_\_\_
3. How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_ Do you feel you have bad breath? ...
4. Do your gums bleed easily? .....
5. Are your teeth sensitive to:  Hot  Cold  Biting  Sweets? .....
6. Do you smoke or use any other forms of tobacco? .....
7. Have you ever experienced any of the following jaw problems: .....
- Popping/Clicking in your jaw joints? .....
  - Pain in your jaw joints, around your ear, side of your face? .....
  - Difficulty in opening or closing? .....
  - Pain or difficulty while chewing? .....
8. Do you mouth breathe while awake or asleep? .....
9. Do you suffer from headaches or migraines? .....
10. Have you had:  Braces  Oral Surgery  Gum Treatment  Root Canal .....
11. Do you grind or clench your teeth during the day or night? .....
12. Have you ever experienced any growths or sore spots in your mouth? If so, where? .....
13. Previous problems with dental treatment? .....
14. Are you satisfied with the appearance of your teeth? .....
15. Please list any other dental concerns or questions: \_\_\_\_\_

**Office policy:** Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require **48 hours** notice, otherwise it may be necessary to charge for the time lost.

**Patient Release:** I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

\_\_\_\_\_  
 (Signature)  Patient  Parent  Guardian

\_\_\_\_\_  
 Reviewing Dentist