

# 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 (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ \ \ \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
          M      D      Y

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	%
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Secondary Ins Co Name \_\_\_\_\_ Group Pol # \_\_\_\_\_ Certif. # \_\_\_\_\_ Yr. End \_\_\_\_\_

Coverage: Basic	%	Prosthetics	%	Crown/Bridge	%	Ortho	%	Perio Scaling	%
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**PERSON RESPONSIBLE FOR ACCOUNT** Self  Other  → Name: \_\_\_\_\_

Address \_\_\_\_\_ Drivers License # \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_ Ext # \_\_\_\_\_ S.I.N: \_\_\_\_\_

**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?					
Are you currently in good health?					
Do you smoke? (If yes, how much?)					
Are you presently taking any medications, pills or drugs?					⇒ If YES, list them here:
Have you had any type of surgery? What & When?					⇒
Have you ever been warned about anaesthetic risks?					
Have you been hospitalized in the past two years? (If yes, why?)					
Do you bruise easily or bleed excessively?					
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?					
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?					

<b>MEDICAL ALERT</b>	<u>CONDITION</u>	<u>PREMEDICATION</u>	<u>ALLERGIES</u>	<u>ANAEST.</u>
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<b>ALLERGIES</b>	<b>Please check off any medications you are allergic to or you have reacted adversely to:</b>				
<input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Codeine	<input type="checkbox"/> Demerol	<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Local Anaesthetic (Freezing)
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Valium	<input type="checkbox"/> Percodan	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Cedhalexin	<input type="checkbox"/> Nitrous Oxide
<input type="checkbox"/> Tylenol	<input type="checkbox"/> Naproxen	<input type="checkbox"/> Latex	<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Sulpha Drugs	<input type="checkbox"/> Amoxicillin
<input type="checkbox"/> Tylenol #2, #3, #4	<input type="checkbox"/> Toradol	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Bandage	<input type="checkbox"/> Metal	<input type="checkbox"/> Chlorhexidene (Peridex)
<input type="checkbox"/> <b>Food Allergies, please list:</b>					
<b>Please list any other medications or substances which you know you are allergic to:</b>					

MEDICAL CONDITIONS	Please check off all of the following conditions you presently have, or have had. (If not sure, check off <u>NS</u> )										
	No	NS	Yes		No	NS	Yes		No	NS	Yes
Malignant Hyperthermia				Scarlet Fever				Rheumatic Fever			
Stomach/Intestinal Problems				Kidney Trouble				Artificial Joints/Hips			
Head/Neck Injuries				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				Swelling of Feet/Ankles/Hands			
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 (infect.)				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				Cancer				X-Ray/Cobalt Treatment			
Cardiac Arrest/ Heart Attack								Chemotherapy/Radiation			

If Yes, have you received treatment?                      Where?

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

<b>WOMEN ONLY</b>	Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking Birth Control Pills? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Are you nursing? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking Fertility drugs? Yes <input type="checkbox"/> No <input type="checkbox"/>

Follow-up information to above questions: