MEDICAL ALERT (office use only) | PATIENT I.D. # | EDI

WELCOME TO OUR OFFICE!

DATE \ \ (M D Y)

PATIENT INFORMATION

To assist the dentist and ensure your well being while undergoing treatment in our office please answer the following questions in detail. Information will be considered confidential and for our records only. Please Print Neatly.

IF YOU HAVE QUESTIONS OR DESIRE ASSISTANCE PLEASE ASK RECEPTIONIST

ADULT INFORMATION

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Name: _____ (last) (first) (initial)

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

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

Business Phone ( ) _____ Ext. _____

Driver's License # _____ Social Insurance # _____

Family Physician: _____ Phone: ( ) _____

Medical Specialist #1 (if presently under care) _____ Phone: ( ) _____

Medical Specialist #2 (if presently under care) _____ Phone: ( ) _____

CHILD INFORMATION

Name: _____ Prefers to be called: _____ (last) (first) (initial)

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

Date of Birth: \ \ (M D Y) Age _____ Sex _____ Home Phone: ( ) _____

Business Phone: ( ) _____ Ext. _____

Family Physician: _____ Phone: ( ) _____

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

School: _____ Grade: _____

If the child's name and/or address is different than yours, or if you are the child's guardian, please complete the adult registration also.

Person Responsible for account: Self ☐ Other ☐ Name: _____ Home Phone: ( ) _____

Address: _____

Business Phone: ( ) _____ Ext. _____

Driver's License # _____ Social Insurance # _____

Occupation: _____

Employed by: _____ Phone: _____ Ext. _____

Spouse Employed by: _____ Phone: _____ Ext. _____

Dental Insurance: Yes ☐ No ☐ Group Policy No.: _____ Certif. No.: _____

Insurance Co. Name: _____

Amount of coverage: Basic _____ % Prosthetics _____ % Crown/Bridge _____ % Ortho _____ % Perio Scaling _____ %

Secondary Insurance: _____ Group Policy No.: _____ Certif. No.: _____

Amount of coverage: Basic _____ % Prosthetics _____ % Crown/Bridge _____ % Ortho _____ % Perio Scaling _____ %

In Case of Emergency Please Notify: _____ Relationship: _____

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

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

Sons _____

Daughters _____

Spouse _____ Other _____

Reason for today's visit: Examination ☐ Emergency ☐ Other ☐ _____

Whom may we thank for referring you to this office? _____

MEDICAL ALERT (office use only) | PRE-MEDICATE

MEDICAL HISTORY

PRESENT PHYSICIAN'S NAME: _____ PHONE: _____

SPECIALIST PHYSICIAN'S NAME: _____ PHONE: _____

Are you presently under Doctor's care? Why? ..... Yes ☐ No ☐

Have you been under Doctor's care in the past two years? Why? ..... Yes ☐ No ☐

Have you taken any medications, pills or drugs in the past two years? ..... Yes ☐ No ☐

Are you presently taking any medications, pills or drugs? ..... Yes ☐ No ☐

(If yes, what?) _____

Have you been hospitalized in the past two years? ..... Yes ☐ No ☐

(If yes, why?) _____

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? ..... Yes ☐ No ☐

Have you ever had any type of surgery? What & When? Yes ☐ No ☐

_____

_____

Do you experience problems with healing? ... Yes ☐ No ☐

Do you wish to speak privately with the Doctor about any problem? ..... Yes ☐ No ☐

Do you smoke? ..... Yes ☐ No ☐

If yes, how much? _____

Are you on a prescription Diet? ..... Yes ☐ No ☐

Have you ever been diagnosed as having a tumor or cancer? ..... Yes ☐ No ☐

Have you ever taken cortisone/steroid medication? ..... Yes ☐ No ☐

Are you currently in good health? ..... Yes ☐ No ☐

Has any family member had any medical conditions? ..... Yes ☐ No ☐

ALLERGIES

Please check off any medications you are allergic to or you have reacted adversely to:

☐ Nembutal	☐ Ibuprofen (Advil)	☐ Demerol	☐ Ampicillin	☐ Rovamycin	☐ Local Anaesthetic (Freezing)
☐ Aspirin	☐ Seconal	☐ Percodan	☐ Erythromycin	☐ Cedhalexin	☐ Nitrous Oxide
☐ Tylenol	☐ Naproxen	☐ Darvon	☐ Clindamycin	☐ Sulfa Drugs	☐ Valium
☐ Tylenol #1,#2,#4	☐ Toradol	☐ Penicillin	☐ Scopolamine	☐ Metal	☐ Chlorhexidene (Peridex)
☐ 222,282,292	☐ Codeine	☐ Amoxicillin	☐ Tetracycline	☐ Latex	

☐ Food Allergies, please list: _____

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

MEDICAL CONDITIONS

Please check off any of the following conditions you presently have or have had.

☐ Heart Failure	☐ Chest Pain	☐ Asthma	☐ Cancer	☐ Bleeding Problems
☐ High Blood Pressure	☐ Angina Pectoris	☐ Hay Fever	☐ Thyroid Disease	☐ Blood Transfusion
☐ Low Blood Pressure	☐ Shortness of Breath	☐ Sinus Trouble	☐ X-Ray or Cobalt Tmt.	☐ Hemophilia
☐ Heart Murmur	☐ Swelling of	☐ Emphysema	☐ Chemotherapy/	☐ AIDS (HIV Positive)
☐ Rheumatic Fever	Feet/Ankles/Hands	☐ Frequent Cough	Radiation	☐ Venereal Disease
☐ Scarlet Fever	☐ Fainting or Dizziness	☐ Lung Disease	☐ Arthritis/Gout	☐ Cold Sores
☐ Congenital Heart Lesion	☐ Stroke	☐ Bronchitis	☐ Rheumatism	☐ Fever Blisters
☐ Artificial Heart Valve	☐ Diabetes or Hypoglycemia	☐ Tuberculosis	☐ Pain in Jaw Joints	☐ Herpes
☐ Heart Pacemaker	☐ Artificial Joints/Hips	☐ Liver Disease	☐ Cortisone/Steroids	☐ Bruise Easily
☐ Heart Surgery	☐ Kidney Trouble	☐ Hepatitis A (infec.)	☐ Glaucoma	☐ Sickle Cell Anemia
☐ Anemia	☐ Ulcers	☐ Hepatitis B (serum)	☐ Epilepsy or Seizures	☐ Blood Disorders
☐ Mitral Valve Prolapse	☐ Allergies	☐ Hepatitis C	☐ Glandular Disorders	☐ Circulation Problems
☐ Cardiac Arrest/	☐ Cosmetic Surgery	☐ Yellow Jaundice	☐ Mental/Nervous	☐ Head/Neck Injuries
Heart Attack	☐ Malignant Hyperthermia	☐ Transdermal	Disorders	☐ Stomach/Intestinal Problems
☐ Hypertension	☐ Tattoos	Nicotine Patches	☐ Psychiatric Care	
☐ Abnormal Bleeding	☐ Drug or alcohol Addiction, if Yes, have you received treatment? _____			

Please list in detail any other serious illness not shown above which you have or may have had: _____

_____

WOMEN ONLY

Are you Pregnant? ..... Yes ☐ No ☐ Due Date: _____ Are you taking birth control pills? ..... Yes ☐ No ☐

CHILD PATIENT ONLY

☐ Measles ☐ Chicken Pox ☐ Tonsillitis

☐ Mumps ☐ Strep Throat ☐ German Measles

Please Indicate approximate date _____

MEDICAL UPDATES

NOTE: IT IS IMPORTANT THAT YOU NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR MEDICAL STATUS.

Since my last visit, my Medical History as noted on this chart (has) or (has not) changed.

DATE	DETAILS	HAS	HAS NOT	PATIENTS SIGNATURE	REVIEWED BY