## Confidential Medical History

Name: _____ Date: ____/____/_____ (dd/mm/yyyy)

Your **physician's** name and phone #: _____ (____)_____

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Are you presently under the care of your physician? more info _____ |
| ☐ | ☐ | 2. Are you presently under the care of a medical specialist? more info _____ |
| ☐ | ☐ | 3. Have you ever had major surgery? (specify) _____ |
| ☐ | ☐ | 4. Are you taking any medications? (specify) _____ |
| | | _____ |
| ☐ | ☐ | 5. Do you have allergies? (specify) _____ |
| ☐ | ☐ | 6. Have you ever experienced any unusual reaction to any of the following: (please circle) Local anesthetic (freezing), penicillin, aspirin, sulfa drugs, codeine, latex, red dye, other |
| ☐ | ☐ | 7. Do you bruise easily or have prolonged bleeding? more info _____ |
| ☐ | ☐ | 8. Do you have heart disease, damaged heart valves, or murmur? (specify) _____ |
| ☐ | ☐ | 9. Do you experience shortness of breath or chest pain? (specify) _____ |
| ☐ | ☐ | 10. Have you ever had an injury to your face, head, or jaw? (specify) _____ |
| ☐ | ☐ | 11. (Women) Are you pregnant? If so, which month are you in? _____ |

**Have you ever been diagnosed or treated for:** (please check)

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart murmur / mitral valve prolapsed | ☐ | ☐ | High/low blood pressure | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Pacemaker | ☐ | ☐ | Diabetes Type I or II | ☐ | ☐ | Lung disease |
| ☐ | ☐ | Heart Disease | ☐ | ☐ | Thyroid disease | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Joint replacement (hip, knee, etc.) | ☐ | ☐ | Cancer | ☐ | ☐ | Hepatitis A/B/C |
| ☐ | ☐ | Scarlet or rheumatic fever | ☐ | ☐ | Liver or kidney disease | ☐ | ☐ | H.I.V. (AIDS) |
| ☐ | ☐ | Heart attack | ☐ | ☐ | Jaundice | ☐ | ☐ | Drug/alcohol addiction |
| ☐ | ☐ | Stroke | ☐ | ☐ | Arthritis or rheumatism | | | |

Are there any other medical concerns we should be aware of? _____

I, the undersigned, state that I have provided an accurate and complete medical/dental history and have not knowingly omitted any information. If I have any change in my health or medication, I will inform the dental staff at my next visit. I understand that providing incorrect information can be dangerous to my health. Finally, I consent to my physician being contacted, if necessary.

_____ ____/____/_____ _____

Signature of patient (parent, guardian) Date (dd/mm/yyyy) Signature of dentist / dental hygienist

**Medical History Update**

| Date dd/mm/yyyy | Current Medical Status | Dr./RDH Sign. | Updated List of Current Medications |
|---|---|---|---|
| __/__/____ | | | |
| __/__/____ | | | |
| __/__/____ | | | |
| __/__/____ | | | |
| __/__/____ | | | |
| __/__/____ | | | |
| __/__/____ | | | |
| __/__/____ | | | |
| __/__/____ | | | |

NIAGARA-ON-THE-LAKE
# DENTAL

## Patient Information

Name: _____

Address: _____

City: _____ Postal Code: _____

Date of Birth: ____/____/_____ (dd/mm/yyyy)

Occupation: _____ How were you referred to us? _____

Person responsible for account Name: _____ Relationship: _____

**Phone Numbers:**

Home: (_____)_____

Business: (_____)_____

Other: (_____)_____

## Dental History

How frequently did you see your dentist? _____

Have you had local anesthetic at the dentist? _____ Any adverse reactions? _____

What do you do at home to care for your teeth? _____

Do your gums ever feel tender or bleed? _____

Have you lost any teeth? _____ If so, why? _____

Do you notice yourself clenching or grinding your teeth? _____

Does your jaw crack or pop when you open/close your mouth? _____

Are you happy with the appearance of your teeth? _____

## Dental Benefits

**If you have a dental plan,** we're pleased to offer you the convenience of direct invoicing to your dental benefit carrier. However, regarding the **Privacy Act,** benefit carriers have been advised not to release information about benefits to anyone other than you, the subscriber. This means they will not discuss your dental benefits, including annual maximums/percentages/limitations – with anyone at our office. Therefore, we require accurate, up to date information regarding your dental benefit plan.

Policy Holder: _____ Date of Birth: ____/____/_____ (dd/mm/yyyy)

Employer: _____ Benefit Carrier: _____

Policy #: _____ Certificate #: _____

## Consent

I consent to the collection and documentation of my personal information, including my medical and dental health history and to the use of such information in any manner or for any purpose whatsoever, but only in the course of, concerning or relating to my dental health care. I similarly consent to the disclosure of all such information to third parties, including dental and/or medical specialists, but only in accordance with the Regulated Heath Professions and the Dentistry and Dental Hygiene Acts of Ontario. I also consent to the disclosure of all such information to any third party benefit carrier or organization responsible for re-imbursement of fees for dental services provided or for purposes of collecting payment for such service.

Further, I consent to your office contacting me directly or leaving a message at ☐ Home ☐ Work ☐ Cell ☐ Other for any and all purposes relating to my dental care and/or appointments.

Signed: _____ Date: ____/____/_____ (dd/mm/yyyy)