WELCOME TO OUR DENTAL OFFICE

MEDICAL ALERT

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

Mr. ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** ☐ **Dr.** ☐ Given Name: _____ Marital Status: _____

Surname: _____ Pronunciation: _____ Prefer to be called _____

Address: (Street) _____ (Apt. #) _____ (City) _____ (Postal Code) _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X ____ Date of Birth: MMM / DD / YY

Fax: (____) _____ - _____ Other: (____) _____ - _____ X ____ ☐ Male ☐ Female ☐ Adult ☐ Child

Employer / School: _____ Occupation: _____

eMail Address: _____ Contact Method _____

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

Are you likely to be available on short notice for future appointments ? ☐ Yes ☐ No

Family Physician: _____ Phone: (____) _____ - _____

In Case of Emergency Notify: _____ Relation: _____ Phone: (____) _____ - _____

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

Name: (Last) _____ (First) _____ (Initial) _____ Relation: _____

Address: (Street) _____ (Apt. #) _____ (City) _____ (Postal Code) _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X ____ DRIVERS LICENCE NUMBER _____

Primary Insurance

Subscriber: _____ Date of Birth: _____

Relation: ☐ Self ☐ Spouse Other: _____

Subscriber I.D.: _____ SIN: _____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Secondary Insurance

Subscriber: _____ Date of Birth: _____

Relation: ☐ Self ☐ Spouse Other: _____

Subscriber I.D.: _____ SIN: _____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Method of Payment: ☐ Cash ☐ Cheque ☐ Credit Card: _____ Number: _____ Exp.: ____

MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

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 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?	☐	☐
11. Do you require pre-medication for dental treatment?	☐	☐

PATIENT REGISTRATION PLEASE COMPLETE MEDICAL/DENTAL HISTORY