Carleton Place Dental Centre

Welcome to our Dental Office

Medical Alert

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

Name:_____ Prefer to be called: _____
(Last) (First) (Initial)

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

Home Phone: _____ Work Phone:_____ Date of Birth: M____ D____ Y _____

Fax:_____ Other Phone: _____ ❑ 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:_____ Phone: _____

In case of emergency notify: _____ Relation: _____ Phone: _____

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

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

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

Home Phone: _____ Work Phone:_____ Driver's License #:_____

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

PRIMARY INSURANCE

Subscriber: _____

Relation: ❑ Self ❑ Spouse ❑ Other _____

Insurance Co.:_____

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

Insurance Co.:_____

Subscriber I.D. or SIN #:_____

SECONDARY INSURANCE

Subscriber: _____

Relation: ❑ Self ❑ Spouse ❑ Other _____

Insurance Co.:_____

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

Insurance Co.:_____

Subscriber I.D. or SIN #:_____

MEDICAL HISTORY

Please ☑ YES or NO to each question. **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 you have any allergic reactions that 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 the following? (please circle): local anaesthesia (freezing), Aspirin, penicillin, 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 normally?	❑	❑

MEDICAL HISTORY

Please ☑ YES or NO to each question. **All information is confidential.**

	YES	NO
11. Have you ever had any organ implants or medical implants?	❑	❑
12. Have you ever fainted?	❑	❑
13. Do your ankles, feet or hands swell?	❑	❑
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	❑	❑
15. Do you have frequent headaches?	❑	❑
16. Do you have A.I.D.S. or have you ever tested positive for H.I.V.?	❑	❑

17. Do you have or ever had any of the following?

❑ Heart Murmur or Mitral Valve Prolapse	❑ Malignant Hyperthermia	❑ Liver Disease	❑ Herpes
❑ Stomach / Intestinal Problems	❑ Drug / Alcohol Dependency	❑ Heart Attack	❑ Sinus Trouble
❑ Joint Replacement (hip, knee, etc.)	❑ Venereal Disease	❑ Cold Sores	❑ Stroke
❑ Mental or Nervous Disorder	❑ Lung Disease (i.e. Asthma)	❑ Jaundice	❑ Kidney problems
❑ High / Low Blood Pressure	❑ Thyroid Disease	❑ Diabetes	❑ Emphysema
❑ Hyper (Hypo) Glycemia	❑ Arthritis or Rheumatism	❑ Tuberculosis	❑ Glaucoma
❑ Epilepsy or Seizures	❑ Scarlet or Rheumatic Fever	❑ Hepatitis A, B, C	
❑ Cortisone / Steroid Therapy	❑ Cancer / Chemotherapy	❑ Other: _____	

	YES	NO
18. Have you had any injury, surgery, or x-ray therapy to your face or jaws?	❑	❑
19. Do you have any disease, condition, or problems that you think the doctor should know about?	❑	❑
20. 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. **All information is confidential.**

	YES	NO
1. Reason for today's visit: ❑ Exam ❑ Cleaning ❑ Emergency ❑ Other _____		
Are you 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? ❑ 6 months ❑ Yearly ❑ Other _____		
Previous Dentist: _____ Last dental visit: _____		
Last cleaning: _____ Full mouth series of x-rays: _____		
3. How often do you brush you 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 had jaw joint surgery?	❑	❑
8. Do you have pain in your jaw joints or suffer from migraine headaches?	❑	❑
9. Does any part of your mouth hurt when clenched?	❑	❑
10. Does your jaw crack or pop when open widely?	❑	❑
11. Have you had: ❑ Braces ❑ Oral Surgery ❑ Gum Treatment ❑ Root Canal	❑	❑
12. Do you grind or clench your teeth during the day or night?	❑	❑
13. Have you ever experienced any growths or sore spots in your mouth? If so, where? _____	❑	❑
14. Have you had previous problems with dental treatments?	❑	❑
15. Are you satisfied with the appearance of your teeth?	❑	❑
16. 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 treatments 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 any my dependents is mine, and I will assume responsibility for fees associated with these services.

Signature: _____ Reviewing Dentist: _____

❑ Patient ❑ Parent ❑ Guardian

Please Print Name: _____ Date: _____