MEDIC ALERT

PERSONAL INFORMATION DATE _____

NAME _____ (Last) _____, _____ (First), _____ (Initial)

SPOUSE _____ PARENTS/GUARDIANS (for minors) _____

ADDRESS _____ EMAIL _____

CITY _____ PROVINCE _____ POSTAL CODE _____

PHONE – Home _____ Work _____ Cell _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PERSON RESPONSIBLE FOR PAYMENT self ☐ spouse ☐ parent ☐ other ☐ _____

DENTAL ASSISTANCE no ☐ yes ☐ INSURANCE CARRIER _____

PHYSICIAN _____ PHONE _____

IN CASE OF EMERGENCY, PLEASE NOTIFY : Name _____ Relationship _____

Phone # of Emergency Contact: _____ DL# _____

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

a. Are you presently under the care of a physician for medical treatment? NO ☐ YES ☐
If yes, explain: _____

b. Have you been hospitalized in the last two years? NO ☐ YES ☐
Specify: _____

c. Do you have a heart murmur or heart disease? NO ☐ YES ☐
Specify: _____

d. Have you had any joint replacements, organ transplants or medical implants? NO ☐ YES ☐
Specify: _____

e. Have you ever used any Tobacco products, Cannabis products or Vaping products? NO ☐ YES ☐
If YES, please circle which one(s) and specify: _____
For how long? _____ How much/often do you smoke? _____
If you have quit, how long ago? _____

f. Have you ever had a reaction to any kind of medication? NO ☐ YES ☐
Allergies - Specify: _____

g. Are you presently taking any kind of medications? NO ☐ YES ☐
Specify:

A) Drug _____ Reason _____

B) Drug _____ Reason _____

C) Drug _____ Reason _____

D) Drug _____ Reason _____

h. Do you or have you had trouble stopping bleeding? NO ☐ YES ☐

i. Have you ever had any injury or surgery to your face or jaws? NO ☐ YES ☐
Specify: _____

j. Do you have frequent/ severe headaches, earaches, or ear/throat infections? NO ☐ YES ☐

k. Do you have hearing difficulties? _____ NO ☐ YES ☐

l. Do you presently have or have you ever had:

Anaemia	NO ☐	YES ☐	Diabetes	NO ☐	YES ☐	HIV Positive Test Result	NO ☐	YES ☐
Arthritis	NO ☐	YES ☐	Emphysema	NO ☐	YES ☐	Kidney Disease	NO ☐	YES ☐
Asthma	NO ☐	YES ☐	Epilepsy/Seizures	NO ☐	YES ☐	Measles/Mumps	NO ☐	YES ☐
Auto Immune Disorders	NO ☐	YES ☐	Glaucoma	NO ☐	YES ☐	Mental/Nervous Disorders	NO ☐	YES ☐
Blood Disorders	NO ☐	YES ☐	Hay Fever	NO ☐	YES ☐	Scarlet/Rheumatic Fever	NO ☐	YES ☐
Cancer	NO ☐	YES ☐	Heart Attack	NO ☐	YES ☐	Stroke	NO ☐	YES ☐
Chicken Pox/Shingles	NO ☐	YES ☐	Hepatitis A, B or C	NO ☐	YES ☐	Tuberculosis	NO ☐	YES ☐

High/Low Blood Press NO ☐ YES ☐ _____

m. Have you had radiation treatment or chemotherapy? NO ☐ YES ☐
Specify: _____

n. Have you ever taken cortisone or steroids? NO ☐ YES ☐
Specify: _____

o. Do you have any physical or mental limitations? NO ☐ YES ☐
Specify: _____

p. Have you ever had any illness/condition not mentioned above? NO ☐ YES ☐
Specify: _____

WOMEN ONLY

Are you pregnant ? If so, what month are you in? _____ NO ☐ YES ☐
Are you taking any birth control pills? NO ☐ YES ☐

DENTAL HISTORY

1. When was your last dental visit? _____

2. How often do you brush your teeth? _____ Floss? _____

3. Have you ever had a local anaesthetic? NO ☐ YES ☐

4. Any complications ? NO ☐ YES ☐ Specify: _____

5. Are any of your teeth sensitive to : NO ☐
Cold ☐ Sweets ☐ Heat ☐ Other: _____

6. Do your gums bleed when you: Brush ☐ Floss ☐ Spontaneously ☐

7. Do you have any swelling or sore spots in your mouth? NO ☐ YES ☐ Specify: _____

8. Do you feel you have bad breath? NO ☐ YES ☐

9. Are you satisfied with the appearance of your teeth? NO ☐ YES ☐
What would you like to see changed? _____

PATIENT CERTIFICATION, APPROVAL AND CONSENT

I certify that the medical information is correct and I consent to my physician being contacted if necessary, as this information may be required for my dental care. I understand that treatment recommendations will be discussed with me following the examination. I will assume responsibility for fees associated with these procedures.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____