NEW PATIENT AND MEDICAL HISTORY QUESTIONNAIRE

ABOUT YOU

Name: _____

I prefer to be called: _____

❒ Male ❒ Female Birth date (D/M/Yr.): _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Home _____ Work _____ ext. _____

Cell _____ email: _____

Check preferred contact: ❒ Home ❒ Cell ❒ Work ❒ Text ❒ Email

Employer: _____

Employer's Address: _____

City: _____ Province: _____ Postal Code: _____

PERSON RESPONSIBLE FOR ACCOUNT

❒ Same as above

Name: _____ Birth date (D/M/Yr.): _____

Relationship: _____

Billing Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Home _____ Work _____ ext. _____

Cell _____ email: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co Name: _____ Group/Policy #: _____

Insured's Name: _____ Birth Date (D/M/Yr.): _____ Relation: _____

Secondary Insurance

Insurance Co Name: _____ Group/Policy #: _____

Insured's Name: _____ Birth Date (D/M/Yr.): _____ Relation: _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: _____

Relationship: _____ Day-time Phone: _____

FAMILY DOCTOR AND MEDICAL SPECIALISTS

Name of Family Doctor: _____

Phone or Address: _____

Medical specialists Name: _____

Area of Specialty: _____

Phone or Address: _____

HOW DID YOU HEAR ABOUT US:

❒ Internet ❒ Sign ❒ Other

❒ Referral - Who should we thank for your referral _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

	YES	NO	NOT SURE/MAYBE
1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? _____	❒	❒	❒
2. When was your last medical checkup? _____			
3. Has there been any change in your general health in the past year? If yes, please explain.	❒	❒	❒
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. _____	❒	❒	❒
5. Do you have any allergies? If you answered yes, please list using the categories below: ❒ Medications _____ ❒ Latex/Rubber Products _____ ❒ other (e.g. hayfever, foods) _____	❒	❒	❒

	YES	NO	NOT SURE/MAYBE
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. _____ _____	❒	❒	❒
7. Do you have or have you ever had asthma?	❒	❒	❒
8. Do you have or have you ever had any heart or blood pressure problems?	❒	❒	❒
9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?	❒	❒	❒
10. Do you have a prosthetic or artificial joint?	❒	❒	❒
11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?	❒	❒	❒
12. Have you ever had hepatitis, jaundice or liver disease?	❒	❒	❒
13. Do you have a bleeding problem or bleeding disorder?	❒	❒	❒
14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. _____ _____	❒	❒	❒

15. Do you have or have you ever had any of the following? Please check.

- ❒ chest pain, angina
- ❒ heart attack
- ❒ stroke
- ❒ shortness of breath
- ❒ rheumatic fever
- ❒ mitral valve prolapse
- ❒ heart murmur
- ❒ pacemaker
- ❒ lung disease
- ❒ tuberculosis
- ❒ cancer
- ❒ steroid therapy
- ❒ diabetes
- ❒ stomach ulcers
- ❒ arthritis
- ❒ seizures (epilepsy)
- ❒ kidney disease
- ❒ thyroid disease
- ❒ drug/alcohol dependency
- ❒ osteoporosis medications (e.g. Fosamax, Actonel)

	YES	NO	NOT SURE/MAYBE
16. Are there any conditions or diseases not listed above that you have or have had? If so, what? _____	❒	❒	❒
17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) _____	❒	❒	❒
18. Do you smoke or chew tobacco products?	❒	❒	❒
19. Are you nervous during dental treatment?	❒	❒	❒
20. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?	❒	❒	❒

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature:_____ Date: _____

Dentist Signature: _____ Date: _____

Dentist's Notes:

_____

_____

_____

_____