

NAME: _____

PARENTS SPOUSE _____

ADDRESS: _____
Street City Postal Code

PHONE: Home _____ Cell _____ Business _____

EMAIL: _____ DATE OF BIRTH: _____
DD/MM/YY

EMPLOYER: _____ SCHOOL: _____

Who referred you to our office? _____

FAMILY DOCTOR _____ PHONE: _____ HEALTH CARD # _____

PHARMACY _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP OF CONTACT: _____

DENTAL INSURANCE: YES NO

SUBSCRIBERS NAME: _____ DOB: _____
DD/MM/YY

EMPLOYER: _____ INSURANCE CO. NAME: _____

POLICY # _____ ID/CONTRACT # _____

MEDICAL HISTORY:

Are you currently receiving medical care? _____ If yes, nature of care: _____

Have you ever been hospitalized? _____ If yes, explain: _____

Do you have any allergies? _____ If yes, explain: _____

Are you allergic to any medication or drugs? _____ If yes, explain: _____

CONFIDENTIAL HEALTH HISTORY

Have you ever had any ill effects or reaction to freezing (local anesthetic) in your mouth? _____

If yes, explain: _____

Have you ever had abnormal bleeding after surgery, injury or dental extractions? _____

Have you taken cortisone or steroids? _____ If yes, when and for how long? _____

CURRENT MEDICATIONS: List any medications and/or supplements (herbal remedies).

1. _____ Dosage: _____ Reason: _____

2. _____ Dosage: _____ Reason: _____

3. _____ Dosage: _____ Reason: _____

4. _____ Dosage: _____ Reason: _____

Do you have or have you ever had any of the following: (please circle or check)

Heart Trouble	Epilepsy	Mental/Nervous Disease	Joint Replacement
High Blood Pressure	Kidney Disease	Cancer	Stroke
Lung Disease	Liver Disease	Radiation Therapy	Heart attack
Asthma	Hepatitis	Chemotherapy	Previous Surgery
Diabetes	Tuberculosis	Osteoporosis	Dental Anxiety
Blood Disorders	Gastrointestinal Disease	Venereal Diseases	Smoking/Vaping
Anemia	Thyroid Condition	HIV infection	Recreational Drugs

Please explain any of the above selected conditions: _____

WOMEN:

Are you pregnant? _____ Nursing? _____ Planning a pregnancy in the near future? _____

Is there anything else the dentist should know regarding your medical/health history?

Date: _____ Signature: _____