Confidential Medical History

Physician's Name: ________________________________ Phone: ____________________

Are you under a physician's care at present? ________________________ Yes No

If yes, why? ____

Have you ever suffered from any major illnesses? ____________________ Yes No

If yes, what? ____

Are you taking any medications of any kind? ________________________ Yes No

If yes, please name these medications: _____________________________________

____

Have you any known allergies? ___________________________________ Yes No

If yes, what are they? ____

Do you, or have you ever had any of the following?

-Heart trouble, heart attack or stroke? ______________________________ Yes No

-Rheumatic fever or heart murmur? _________________________________ Yes No

Have you had to take antibiotic prophylaxis in the past for dental treatment? Yes No

-Chest pain, High Blood Pressure? __________________________________ Yes No

-Diabetes or Hyperthyroidism? _____________________________________ Yes No

-Seizures, convulsions or epilepsy? __________________________________ Yes No

-Jaundice or liver disease? ____ Yes No

-Infectious or communicable disease? If yes, identify _________________ Yes No

Do you have any other medical conditions (i.e.HIV, Hepatitis, Herpes) that are important for the dentist to know about? ____________________________________ Yes No

Do you have any blood disorders or do you bleed excessively? __________ Yes No

If yes, please explain :____

Women: Are you pregnant? ______________________________________ Yes No

If yes, what is your due date? ___________________________________

Signature: ____________________________________ Date: ________________________

Welcome!

Dr.
Mr.
Ms. ____ Birthdate __________________
Mrs. Surname Given names Month/Day/Year
Miss

Preferred Name:______________________________ Name of spouse _______________

Home address____
House/apt # street City Postal Code

Business address____
Suite/Bldg# street City Postal Code

Phone: Home: ________________ Business _________________ Cel: __________________

Email address: ____

Whom may we thank for referring you to our office? ____________________________________

Emergency Contact: _____________________Phone:____________ Relationship_____________

Payment method: Cash, cheque, MasterCard, visa or interact are accepted

Patients under the age of 19, please list the first and last names of your parents/guardians:

1)____________________________________ 2)_________________________________
Parent/Guardian Parent/Guardian

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his or her staff, and assume financial responsibility.

Signature: ___________________________________ Date: ________________________

Dental Insurance Information

Name of insurance company:________________________ Employer:__________________

Policy Holder name: ___________________________ Policyholder's birthdate:___________

Group/Policy/Contract#_________________________ SIN __________________________

ID or certificate # __________________ Division#_________________Dependant#______

Coverage % A/Basic ______B/Major ______C/ortho________Financial Limits _____________

Deductible _______________________ Fee Schedule (Pacific Blue Cross only) ____________

Do you have additional dental insurance coverage? __________________________________

PLEASE TURN OVER