PATIENT MEDICAL HISTORY & UPDATE FORM

We are committed to providing you the most comprehensive care and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better care we can give you. If you have any questions or need assistance, please ask us – we will be happy to help!

ABOUT YOU

Name: _____ Birthday: DD / MM / YYYY Age: _____ Marital Status: _____

Address: _____ City: _____ Postal Code: _____

Home phone: _____ Work: _____ Ext.: _____ Cell: _____

Email Address: _____ Preferred method of contact: Text ☐ Call ☐ Email ☐

Do you consent to receive occasional information and promotions? Yes ☐ No ☐

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above

Name: _____ Relation: _____

Billing Address: _____ City: _____ Postal Code: _____ Home phone: _____ Cell: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone #: _____

MEDICAL HISTORY

Family Physician _____ Phone #: _____

Preferred Pharmacy _____ Phone #: _____

1. When was your last visit to your family physician? _____

2. Have you been hospitalized in the past two years? ..... Yes ☐ No ☐

If yes, why? _____

3. Please list any **medications/drugs** you are taking and **what you are taking them for**: _____

_____

4. Do you use the following? (If yes, please check box)

☐ tobacco ☐ vaping ☐ cannabis

5. Have you experienced any unusual reaction to the following? (If yes, please check the box)

☐ aspirin ☐ penicillin ☐ ativan ☐ codeine ☐ local anaesthetic ☐ latex

6. Do you have allergies of any kind? .....Yes ☐ No ☐

If yes, what? _____

7. Do you have anemia or bleed abnormally? ..... Yes ☐ No ☐

8. Have you ever had any of the following diseases or conditions? (If yes, please check the box and fill in blanks)

- ☐ **H.I.V.**
- ☐ **Asthma: Type: _____**
- ☐ **Cancer: Type: _____**
- ☐ **Diabetes: Type _____**
- ☐ **Epilepsy**
- ☐ **Stomach Issues: _____**
- ☐ **High Cholesterol**
- ☐ **Heart murmur**
- ☐ **Heart problems: _____**
- ☐ **Hepatitis A, B or C (Circle)**
- ☐ **High blood pressure**
- ☐ **Jaundice**
- ☐ **Kidney disease**
- ☐ **Mental health issues**
- ☐ **Radiation: Area/Date: _____/_____**
- ☐ **Stroke**
- ☐ **Tuberculosis**
- ☐ **Thyroid disease: Hypo / Hyper (Circle)**
- ☐ **Ulcers**

Notes:

_____

_____

_____

9. Are there any other medical problems we should be aware of? ..... Yes ☐ No ☐

If yes, what? _____

10. Have you been advised to take antibiotics before dental treatment? ..... Yes ☐ No ☐

11. Women: Are you presently pregnant or breastfeeding? ..... Yes ☐ No ☐

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I authorize the dentist to preform procedures and consent to the treatment including the use of local anaesthetic, oral sedation, and I will assume responsibility for fees associated with those procedures. I authorize the release of my personal information regarding my diagnosis or treatment to my insurance company or any other dental profession.

_____ DD / MM / YYYY _____

Signature: ☐ Patient ☐ Parent ☐ Guardian **Date** **Print name of parent / guardian**

Need more information? Ask us now. Were happy to help.