Eighty Eight

FINCH EAST DENTAL

416 221 8828

CONFIDENTIAL PATIENT RECORD

Patient Name: First _____ Last _____

Date of Birth: Day: _____ Mo: _____ Yr: _____ Gender: □ F □ M Medical Alert: _____

Address: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____

Email Address: _____

Family Doctor: _____ Phone Number: _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

1. Are you currently in good health? □ Yes □ No If No, please explain _____

2. Are you presently under the care of a physician? □ Yes □ No If Yes, please explain _____

3. Are you currently taking any medications? □ Yes □ No Please list: _____

4. Are you allergic to or ever had a reaction to any of the following: *(Please circle all that apply)*

Penicillin Sulfa drugs *Local Anaesthetic (freezing)* *Latex*

Codeine *Aspirin (ASA)* *Other* _____

5. Do you have any allergies?

6. Have you ever taken cortisone or steroid medications? E.g. Prednisone □ Yes □ No

7. Have you ever had chemotherapy or radiation therapy? □ Yes □ No

8. Do you smoke or chew tobacco? □ Yes □ No

9. Do you bleed longer than normal after a cut/surgery/previous tooth removal? □ Yes □ No

10. Have you been hospitalized in the last 2 years? □ Yes □ No If yes please explain

_____

11. Have you ever had a serious illness or operation? □ Yes □ No

12. Do you have or ever had any of the following conditions? *(Please circle all that apply)*

Heart Trouble *Joint Surgery* *Thyroid Disorder* *Breathing Problems* *Stroke* *Blood Disorders*

HIV Positive *Rheumatic Fever* *Heart Defect* *Kidney Disease* *Arthritis* *Hepatitis*

Mental Illness *High/Low Blood Pressure* *Diabetes* *Tumors or Cancer* *Epilepsy or Seizures*

Liver Disease *Hormonal Disorder* *Immune Deficiency* *Sexually Transmitted Disease (STD)*

Asthma *Multiple Sclerosis (MS)* *Tuberculosis* *Other* _____

9. **WOMEN:** Are you pregnant? □ Yes □ No

14. Is there anything else we should know about your health? _____

_____

DENTAL HISTORY

1. What dental condition(s) concern you at present? _____

2. When was your last dental check up and cleaning appointment? _____

3. Have you had any complications or difficulty with previous dental treatment? □ Yes □ No

4. Are your teeth sensitive to: □ Hot □ Cold □ Sweet □ Other _____

5. Do your gums bleed when: □ Flossing □ Brushing □ Never

6. Do your gums feel swollen or tender? □ Yes □ No

7. Do you have bad breath or a bad taste in your mouth? □ Yes □ No

8. Are you interested in having teeth whitening? □ Yes □ No

9. Do you grind your teeth and have TMJ problems? □ Yes □ No

10. How do you describe yourself as a patient? □ Calm □ Slightly nervous □ Apprehensive

CONSENT FOR TREATMENT

I hereby certify that Medical and Dental Histories are accurate and complete to the best of my knowledge. I consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anaesthetic or any drugs as indicated:

(Children under 16 years of age must have parents or guardian signature)

Date: _____ *Signature:* _____

ELECTRONIC SUBMISSIONS

I authorize release to my insuring company plan administrator the information contained in claims submitted electronically.

Date: _____ *Signature:* _____