

# WELCOME TO OUR DENTAL OFFICE

# MEDICAL ALERT

Mr.  Mrs.  Miss  Ms.  Dr.   ADULT  CHILD

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Initial) \_\_\_\_\_ Prefer to be Called: \_\_\_\_\_

Address: (Street) \_\_\_\_\_ (Apt.#) \_\_\_\_\_ (City) \_\_\_\_\_ (Postal Code) \_\_\_\_\_  
MM DD YY

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ X \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_ Other: ( ) \_\_\_\_\_ - \_\_\_\_\_ X \_\_\_\_\_  Male  Female

Employer / School: \_\_\_\_\_ Occupation: \_\_\_\_\_

eMail ID: \_\_\_\_\_ Who may we thank for referring you to this office?: \_\_\_\_\_

Are you likely to be available on short notice for future appointments or appointment changes?  Yes  No

Family Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Person responsible for this account:  Self  Spouse  Parent  Legal Guardian  Other: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Initial) \_\_\_\_\_ Relation: \_\_\_\_\_

Address: (Street) \_\_\_\_\_ (Apt.#) \_\_\_\_\_ (City) \_\_\_\_\_ (Postal Code) \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ X \_\_\_\_\_

### Primary Insurance

Subscriber: \_\_\_\_\_

Relation:  Self  Spouse Other: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Policy/Plan #: \_\_\_\_\_ Division/ Sect. #: \_\_\_\_\_

Subscriber I.D. \_\_\_\_\_ SIN \_\_\_\_\_

Are You Familiar with Your Plan Details?  Yes  No

### Secondary Insurance

Subscriber: \_\_\_\_\_

Relation:  Spouse Other: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Policy/Plan #: \_\_\_\_\_ Division/ Sect. #: \_\_\_\_\_

Subscriber I.D. \_\_\_\_\_ SIN \_\_\_\_\_

Are You Familiar with Your Plan Details?  Yes  No

Method of Payment  Cash  Cheque  Credit Card: \_\_\_\_\_ Number: \_\_\_\_\_ Exp.: \_\_\_\_\_

## MEDICAL HISTORY ALL INFORMATION IS CONFIDENTIAL

The following information is required by the dentist to assist in proper diagnosis and treatment. YES NO

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? .....    
Please specify: \_\_\_\_\_
2. Are you presently under the care of a physician? .....    
If so, please explain: \_\_\_\_\_
3. Have you had a medical examination in the last year? .....
4. Do you use any prescription or non-prescription drugs regularly? .....    
Please specify: \_\_\_\_\_
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? .....
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? .....    
Please specify: \_\_\_\_\_
7. Have you been hospitalized in the last 5 years? .....    
Please specify: \_\_\_\_\_
8. Have you ever experienced any unusual reaction to any of the following? (Please circle) .....    
local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or  
any other medicine? If so please explain \_\_\_\_\_
9. Have you been warned against taking any drug or medication? .....
10. Do you bruise easily or bleed abnormally? .....

