ST MARYS DENTISTRY/ Medical and Dental History

Name: _____ Date of Birth: _____/_____/_____
D M Y

Address: _____

Complete mailing address, including PO Box or "911" number.

City: _____ Province: _____ Postal Code_____

Telephone(s) _____ _____ _____
Home Work Mobile

Please indicate the phone number where we have permission to contact you: _____

Email Address: _____

Previous Dentist: _____ Telephone _____

Whom may we thank for referring you to us? _____

Who is responsible for your account? □ Self □ Spouse □ Parent □ Guardian □ Friend

Name: _____ Telephone _____

Employer Information: _____

May we contact you at work? □ Yes □ No

Do you have dental insurance? □ Yes □ No

Medical History

Your answers are for our records only, and will be considered confidential.
These facts have a direct bearing on your dental health.

Name of Physician: _____Telephone: _____

Date of last physical examination: _____

Medical Specialist: _____ Telephone: _____
Dr's Name and Specialty

Emergency Contact: _____ Telephone: _____
Relationship: □Spouse □ Parent □ Guardian □ Friend

For the following question, circle yes or no, whichever applies.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the year?..... Yes No
3. Are you now under a physician's care?..... Yes No
4. Have you had any serious illness or operation?..... Yes No
   If so, please list: _____
5. Have you been hospitalized or had a serious illness within the past 5 years? Yes No
   If yes, what reason? _____

Cardiovascular System

1. Do you have or have you ever had any of the following (please circle):
   Heart trouble Heart attack Stroke Damaged heart valves
   Congenital heart disease Coronary insufficiency None

2. Rheumatic heart disease or Heart murmur?..... Yes No
3. Chest pain after exertion?..... Yes No
4. Do you have a cardiac pacemaker?..... Yes No
5. Do you have any blood pressure problems?..... Yes No

   High _____ Low _____

Central Nervous System

1. Do you have or have you ever had:
   a. Epilepsy?..... Yes No
   b. Fainting Spells?..... Yes No
   c. Seizures?..... Yes No
   d. Emotional disturbances?..... Yes No
2. Do you follow any treatment for a nervous disease?..... Yes No

Respiratory System

1. Do you have or have you ever had Tuberculosis?..... Yes No
2. Is there any history of Tuberculosis in your family?..... Yes No
3. Do you have Emphysema, Chronic Bronchitis or Asthma?..... Yes No
4. Do you have any sinusitis or sinus trouble?..... Yes No

Digestive System

1. Do you have any stomach ulcers?..... Yes No
2. Do you have or have you ever had;
   a. Hepatitis?..... Yes No
   b. Jaundice?..... Yes No
   c. Liver Disease?..... Yes No

Endocrine System

1. Do you have Diabetes?..... Yes No
2. Do you have Hypothyroidism?..... Yes No
3. Do you have Hyperthyroidism?..... Yes No

Hematopoietic System (blood)

1. Do you have Anemia, Sickle cell disease or any Blood disorders?..... Yes No
2. Are you hemophilic?..... Yes No
3. Have you had abnormal bleeding after any surgery, extraction or trauma?.... Yes No
4. Have you ever had a blood transfusion?..... Yes No

Allergies

1. Are you allergic to or have you acted adversely to:
   a) Local Anaesthetics?..... Yes No
   b) Antibiotics, Penicillin, or Sulpha drugs?..... Yes No
   c) Barbiturates, sedatives, or sleeping pills?..... Yes No
   d) Aspirin?..... Yes No
   e) Codeine or other narcotics?..... Yes No
   f) Other? _____ Yes No
2. Do you have Asthma or Hay Fever?..... Yes No
3. Do you have or have you ever had Hives or Skin rash?..... Yes No

   If you answered yes to any of the allergy questions, please provide more information:

   _____

Genitourinary System

1. Do you have or have you ever had kidney trouble?..... Yes No
2. Have you been exposed to the HIV virus?..... Yes No
3. Do you have AIDS?..... Yes No

Bone and Joints

1. Do you have:
   a) Arthritis?..... Yes No
   b) Artificial Joints?..... Yes No
      If yes, when did you have the replacement? _____
   c) Bone Infection?..... Yes No
   d) Osteoporosis?..... Yes No

Neoplasms

1. Do you have or have you ever had:
   a) Tumor or malignancy?..... Yes No
   b) Chemotherapy or Radiation therapy?..... Yes No

Miscellaneous

1. Do you drink alcohol?..... Yes No
   If yes, how much and how often?_____
2. Do you smoke or use tobacco?..... Yes No
   If yes, how much and how often?_____
3. Do you use Drug recreationally?..... Yes No
   If yes, what drugs, how much, and how often?_____

Medications

1. Are you taking any of the following medications?
   a) Antibiotics or sulpha drugs?..... Yes No
   b) Anticoagulants (blood thinners)?..... Yes No
   c) Medicine for high blood pressure?..... Yes No
   d) Tranquilizers?..... Yes No
   e) Codeine or other Narcotics?..... Yes No
   f) Other?..... Yes No

If you are taking medication, please give details of the name of the medication, the dose and frequency, and the reason for use.

_____

_____

_____

_____

_____

Women

1. Are you Pregnant?..... Yes No
   If yes, when are you due? _____
2. Are you nursing?..... Yes No
3. Are you taking Oral Contraceptives or Hormonal Therapy?..... Yes No

Dental History

1. Do you see a dentist on a routine basis? Yes No Date of your last dental visit _____
2. How would you rate your dental health? □ Excellent □ Good □ Fair □ Poor
3. Are you experiencing any discomfort or pain at this time?..... Yes No
4. Are you satisfied with the appearance of your teeth?..... Yes No
5. Do you have headaches, earaches or neck pain?..... Yes No
6. Do you have any problems with your jaw?..... Yes No
7. Do you have problems with your bite?..... Yes No
8. Have you had serious trouble associated with previous dental treatment?..... Yes No
   If yes, please explain:
   _____
9. Do you gag easily ..... Yes No
10. Do you experience dry mouth? ..... Yes No
11. Do you have any of the following habits? □ Clenching or grinding (awake or asleep) □ Bite your lip or cheeks
    □ Hold/bite foreign objects □ mouth breathe

Are you concerned about the appearance of your teeth?..... Yes No

If so, what would you like to see changed? _____

Insurance companies now only allow for *"functionally acceptable work"*. In the past their coverage was for *"quality work"*. It is our desire to provide our patients with the highest quality work within their financial capabilities and expectations.

What is important to you (check one)

□ The highest quality dentistry available

□ The most economical treatment plan

□ Dentistry limited to my insurance coverage

□ A combination of the above, please explain:_____

Additional Information

Is there anything in your medical and dental history that we have not specifically asked about that we should be made aware of? If so, please explain: _____

_____

_____

_____

□ I have read and answered all of the questions listed above, and I certify that the information is complete and correct to the best of my knowledge. I also consent to necessary contact with my physician for more information.

I have reviewed the information that explains how your office will use my personal information. I know your office has a Privacy Code, and that I can see the Code at any time. I agree that St Marys Dentistry can collect, use and disclose personal information about me as set out in their office's privacy policies.

I, the undersigned, hereby authorize the Dentist to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of my dental needs.

I also authorize the Dentist to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with *(name of patient)*_____ after discussion and consultation between the named patient (or guardian of) and the dentist, including alternative options or the consequences of no treatment. I also understand the use of anesthetic agents involves a certain risk.

Patient (Parent or Guardian) Signature _____ Date _____

Dentist's Signature _____