

MEDICAL AND DENTAL HISTORY

Date: _____

Name: _____

Date of birth: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

E-Mail Address: _____

Place of Employment: _____ Occupation: _____

Please circle one : single married widowed separated divorced

Whom may we thank for referring you? _____

IF MARRIED: (For contact information) Spouse's Name: _____

Place of employment : _____ Spouse's Business Phone: _____

DENTAL INSURANCE INFORMATION :

Insured's name : _____ Insured's date of birth: _____

Insured's employer : _____

Company : _____ Policy #: _____ I.D. or certificate #: _____

Person responsible for the account : _____

MEDICAL HISTORY

Your answers are for our records only, and will be considered confidential.

These facts have a direct bearing on your dental health.

Gender : _____ Age : _____

Name of Physician : _____

Address of Physician : _____

Date of last physical examination : _____

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

1. Are you in general 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
 If yes, for what condition? _____
4. Have you had any serious illness or operation? _____ Yes No
5. Have you been hospitalized or had a serious illness within the past 5 years? _____ Yes No
 If yes, what reason? _____
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Cardiovascular system

1. Do you have or have you ever had any of the following (please circle): _____ None
 Heart trouble Heart attack Stroke
 Damaged heart valves Congenital heart disease Coronary insufficiency
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 any sinusitis or sinus trouble? _____ Yes No
4. Do you have Emphysema, Chronic Bronchitis or Asthma? _____ 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

- 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 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 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. Inflammatory Rheumatism? _____ Yes No
 - 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. Are you wearing, or do you wear contact lenses? _____ Yes No
2. Do you drink alcohol? _____ Yes No
If yes, how much and how often? _____
3. Do you smoke or use tobacco? _____ Yes No
If yes, 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 any medications, 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
2. Are you nursing? _____ Yes No
3. Are you taking Oral Contraceptives or Hormonal Therapy? _____ Yes No

DENTAL HISTORY

1. What is your chief complaint about your teeth?

2. How would you like us to help you?

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. Are you able to eat and chew foods satisfactorily? _____ Yes No
6. Do you have headaches, earaches or neck pain? _____ Yes No
7. Do you have any problems with your jaw joints? _____ Yes No
8. Do you have any problems with your bite? _____ Yes No
9. Have you had serious trouble associated with previous dental treatment? _____ Yes No

If yes, please explain:

Denture Patients

1. Do you wear partial or complete dentures? _____ Yes No
If yes, what do you have and when were they made? _____
2. Do your dentures move during function? _____ Yes No
3. Do your dentures hurt? _____ Yes No
4. Can you eat properly with your dentures? _____ Yes No
5. Do your dentures drop and cause social embarrassment? _____ Yes No
6. Are you satisfied with your facial appearance? _____ Yes No
7. Are they satisfactory? _____ Yes No

Please expand on any problems and indicate any other denture concerns that you may have:

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? _____

RESPONSIBILITY AND CONSENT FORM

I hereby authorize and request the performance of dental services for myself or for:

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes or dental treatment.

These records may include study models, photographs and x-rays, which may be used for dental education and used in dental publications.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

I also understand that the treatment estimate presented to me is only an estimate.

Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee.

I believe the information given in the six pages of this medical and dental history to be true to the best of my knowledge.

Signature of Patient or Guardian: _____

Signature of Doctor: _____

Date: _____

To are Valued Clients

At Viana Family Dental Centre, our team strives to provide you the very best service and quality of care. We want to remind you that your appointment is reserved exclusively for you. If you will be unable to keep your appointment we ask that you give us two working days' notice so that another patient can be seen in that time.

Failure to notify us may result in a cancellation fee being charged to your account

Your cooperation is greatly appreciated.

Yours Truly,

The Team at Viana Family Dental Centre

Dr. Paulo Viana

Signature of Patient _____