

Confidential Medical Form

Personal Information

Last name: _____ First name: _____ Sex: F M
Address: _____ City: _____ Postal code: _____
Home telephone No: _____ Work telephone No: _____ Ext: _____
Cell: _____ E-mail: _____ Birth date (MM/DD/YYYY): _____
Medicare Card No: _____ Expiry: Year: _____ Month: _____
Social Insurance No. (optional): _____
If you are less than 18 y-o, indicate name of parent/guardian: _____ Parent or Guardian
In case of emergency call: _____
Reason for visit: _____ Referred by: _____

Medical History

Weight: _____ Height: _____ Are you currently under the care of a physician? yes no
If so, reason: _____
Physician's name: _____ Physician's Telephone No: _____
Are you currently taking or have you taken any medication in the last six months? yes no
If yes, please describe them: _____
Are you presently taking natural or homeopathic products? yes no Specify: _____
Are you taking birth control pills? yes no Hormones? yes no Specify: _____
Did you have a weight loss or gain lately? yes no
Are you pregnant? yes no Are you breastfeeding? yes no

Do you or have you ever had any of the following:

Heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatic fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Hemophilia	<input type="checkbox"/> yes <input type="checkbox"/> no	Prolonged bleeding	<input type="checkbox"/> yes <input type="checkbox"/> no
Clear blood	<input type="checkbox"/> yes <input type="checkbox"/> no	Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no
Other blood problems?			
High or low blood pressure:	<input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> High		
Frequent colds or sinusitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis or lung problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Digestive problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Specify the digestive problem:	
Stomach ulcers	<input type="checkbox"/> yes <input type="checkbox"/> no	Liver problems (hepatitis A, B, C or cirrhosis)	<input type="checkbox"/> yes <input type="checkbox"/> no
Kidney problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you urinate often?	<input type="checkbox"/> yes <input type="checkbox"/> no
Sexually transmitted infections	<input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no
Thyroid problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Skin disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Vision problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no
Osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you take biphosphonates?	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	Nerve problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Mental illness	<input type="checkbox"/> yes <input type="checkbox"/> no	Specify the illness:	
Frequent headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	Dizziness or fainting	<input type="checkbox"/> yes <input type="checkbox"/> no

Earaches	yes	no	Hay fever	yes	no
Asthma	yes	no	Do you smoke?	yes	no
Have you ever had radiation treatments or chemotherapy?	yes	no	Do you have AIDS?	yes	no
Have you tested positive for AIDS?	yes	no	Do you have any artificial joints?	yes	no
Do you snore or have you ever been told that you snore?	yes	no			

Have you ever had an allergic reaction to any of the following:

Foods	yes	no	Latex	yes	no	Penicillin	yes	no
Aspirin	yes	no	Iodine	yes	no	Sulpha drugs	yes	no
Codeine	yes	no	Local anesthetic	yes	no	Other antibiotics	yes	no

Other products, please specify:

Do you use drugs? yes no

Do you drink alcohol? No/A little In Moderation A lot

Have you ever been hospitalized or had surgery other than dental? yes no

If yes, specify the type of surgery and when?

Do you fear dental treatments? yes no

Do you wish to discuss your health privately with your dentist? yes no

Comments:

Dental History

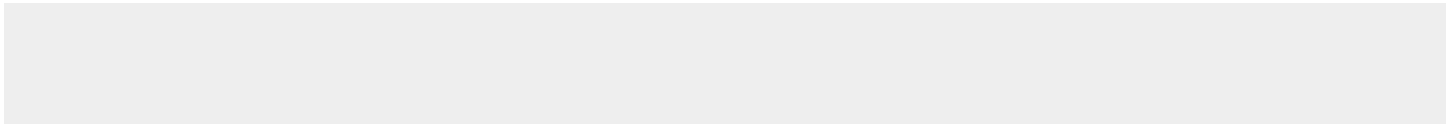
Date of last dental visit: 0-6 months 6-12 months + than 12 months

Treatment received:

Have you had any of the following dental treatments or services?

Oral hygiene demonstration	yes	no	Gum treatment	yes	no
Orthodontic treatment (braces)	yes	no	Root canal treatment	yes	no
Fillings	yes	no	Crown(s) or bridge(s)	yes	no
Full or partial dentures	yes	no	Dental surgery or extraction	yes	no
Dental implants	yes	no	Dental X-rays	yes	no
Others	yes	no			

For professional use only:



RESERVED FOR DENTIST'S USE

I acknowledge that I have read the answers in the registration questionnaire and that I have taken the customary measures, as applicable.

Signature: _____ Date: _____

I, the undersigned, hereby declare that I have read, understood, informed myself about and answered the medical-dental questionnaire to the best of my knowledge. I hereby promise to inform you of any change in the state of my health. I authorize the creation of my dental chart, its follow-up, as well as my registration on the recall list of the attending dentist(s). I have been informed that my chart will be kept in the office at all times and that only the dentist(s) and his/her (their) support staff will have access to it. I have also been informed of my right to consult my chart, to request that it be corrected and to remove my name from the recall list.

Signature: _____ Date: _____