NOSEHILL DENTAL CENTRE

A Team of General Dentists Providing Excellence In Treatment, Service and Care

Today's Date _____ / _____ / _____ **Dentist:** _____
D M Y

Patient Information:

Name: _____ _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Minor
Last First

Address: _____
Street City Prov. Postal Code

Telephone: _____ _____ **(Home)** _____ _____**(Office)** _____ **(Cell)** _____**(Email)**

Birthdate: _____/ _____/ _____ ☐ **Male** ☐ **Female** **AHC#**_____
D M Y

Insurance Information:

Name of insured _____**Relationship to patient**_____

Insured's Birthdate _____ **D** _____**M** _____**Y** _____ **Name of Employer** _____

Insurance Co: _____ **Group #** _____ **Division #** _____

Employee Id # or SIN # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE _____ **YES** _____**NO**
If yes, complete the following:

Name of insured _____**Relationship to patient**_____

Insured's Birthdate _____**D**_____**M**_____**Y**_____ **Name of Employer** _____

Insurance Co: _____ **Group #** _____ **Division #** _____

Employee Id # or SIN # _____

Whom may we thank for referring you to our office? _____

☐ **Family Referred** ☐ **Friend referred** ☐ **Location** ☐**Website/Google** ☐ **Yellow Pages** ☐ **Local Advertising** ☐ **Other**

Consent for Services

I understand that I am personally responsible for payment of all dental services rendered. Our practice will on your behalf help prepare patients insurance forms or assist in making collections from the insurance company and will credit any such collections to your account. Dental insurance plays a role in helping patients to acquire dental care however it cannot interfere with the proper diagnosis and treatment recommendations. Treatment recommendations are made on your dental health needs not on what insurance coverage you may or may not have. **I understand that the fees estimated for dental care can only be extended for a period of 3 months** from the date of the patient exam. The undersigned affirm that the information given in this questionnaire is true and accurate to the best of their knowledge. **I authorize the dental staff to perform such dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company for legal documentation.**

I have read the above conditions of treatment and agree to their content. Date _____/ _____/_____

_____ _____ _____
Print Name Signature Relationship (Parent)

Confidential Medical Information

Patient Name:_____Nickname: _____Age: _____

Name of Physician / and their specialty _____

Most recent Physical Examination: _____

What is your estimate of your general health? Excellent Good Fair Poor (please circle)

DO YOU HAVE OR HAVE YOU EVER HAD? Please circle: yes or no

1	Hospitalization for illness or injury _____	yes / no	26	Osteoporosis/Osteopenia (taking bisphosphates) _____	yes / no
2	An allergic reaction to:		27	Arthritis, Rheumatoid arthritis, lupus _____	yes / no
	Aspirin, Ibuprofen, Acetaminophen, Codeine	yes / no	28	Glaucoma _____	yes / no
	Penicillin	yes / no	29	Contact Lenses _____	yes / no
	Erythromycin	yes / no	30	Head or neck injuries _____	yes / no
	Sulfa Drugs	yes / no	31	Epilepsy, convulsions (seizures) _____	yes / no
	Local Anesthetic	yes / no	32	Neurologic disorders (ADD/ADHD, prion disease) _____	yes / no
	Fluoride	yes / no	33	Viral infections and cold sores _____	yes / no
	Metals (nickel, gold, silver, etc. _____	yes / no	34	Lumps or swelling in the mouth _____	yes / no
	Latex	yes / no	35	Hives, skin rashes, hay fever _____	yes / no
	Other _____	yes / no	36	STI / STD _____	yes / no
3	Heart problems, or cardiac stint within last 6 months _____	yes / no	37	Hepatitis (type _____) _____	yes / no
4	History of infective endocarditis _____	yes / no	38	HIV / AIDS _____	yes / no
5	Artificial heart valve, repaired heart defect (PFO) _____	yes / no	39	Tumor, abnormal growth _____	yes / no
6	Pacemaker or implantable defibrillator _____	yes / no	40	Radiation Therapy _____	yes / no
7	Artificial Prosthesis (heart valve or joint) _____	yes / no	41	Chemotherapy, immunosuppressive _____	yes / no
8	Rheumatic or Scarlet fever _____	yes / no	42	Emotional problems _____	yes / no
9	High or Low blood pressure _____	yes / no	43	Psychiatric treatment _____	yes / no
10	A stroke (taking blood thinners) _____	yes / no	44	Antidepressant Medication _____	yes / no
11	Anemia or blood disorder _____	yes / no	45	Alcohol/ Street drug use _____	yes / no
12	Prolonged bleeding due to slight cut (INR>3.5) _____	yes / no		ARE YOU:	
13	Emphysema, shortness of breath, sarcoidosis _____	yes / no	46	Presently being treated for any illness _____	yes / no
14	Tuberculosis, measles, chicken pox _____	yes / no	47	Aware of a change in your health in the past 24 hrs. _____	yes / no
15	Asthma _____	yes / no		(fever, chills, new cough or diarrhea)	
16	Breathing/sleep problems, sleep apnea. Snoring, sinus _____	yes / no	48	Taking medication for weight management (fen-phen) ___	yes / no
17	Kidney disease _____	yes / no	49	Taking dietary supplements	yes / no
18	Liver disease _____	yes / no	50	Often exhausted or fatigued _____	yes / no
19	Jaundice _____	yes / no	51	Experiencing frequent headaches _____	yes / no
20	Thyroid, parathyroid, or calcium deficiency _____	yes / no	52	A smoker, previously smoked or use smokeless tobacco __	yes / no
21	Hormone deficiency _____	yes / no	53	Often unhappy, depressed _____	yes / no
22	High cholesterol or taking statin drugs _____	yes / no	54	FEMALE: taking birth control _____	yes / no
23	Diabetes (HbA1c = _____) _____	yes / no	55	FEMALE: pregnant/breastfeeding _____	yes / no
24	Stomach or duodenal ulcer _____	yes / no	56	MALE: prostrate disorders _____	yes / no
25	Digestive disorders (celiac disease, gastric reflux, etc.) _____	yes / no			

Describe any current medical treatment, impending surgery, genetic/development delay, other treatment that may possibly affect your dental treatment

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List all Medications, supplements, and or vitamins taken within the last two years

DRUG	PURPOSE	DRUG	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please ask for an additional sheet if needed.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

ARE YOU REQUIRED TO TAKE ANY PREMEDICATION PRIOR TO DENTISTRY? ☐ NO ☐ YES _____

ARE THERE ANY MEDICATIONS YOU HAVE BEEN DIRECTED NOT TO TAKE? _____

Patient's Signature _____ Date _____

Doctor's Signature_____ Date _____