Welcome to Donly Dental! *Medical and Dental History Form*

Date ________________

PATIENT INFORMATION

(please circle) Mr Mrs Miss Ms Dr

Name (first) ______________________ (last) ______________________ (preferred) ______________________

Address (no & street) ______________________ (city) ______________ (postal code) ______________

Date of Birth (month) ____________ (day) ________ (year) ____________ Age ______________________

Marital Status ______________ Spouse Name ______________ Spouse Date of Birth ____________

Phone #'s

Home: ______________________________ Work: ______________________________

Cell: ______________________________ Email: ______________________________

Which do you prefer to confirm your appointments? Text Message (*most popular*) / Email / Voice Call?

Family Doctor ______________________________ Pharmacy: ______________________________

Your Place of Employment ____

Spouse's Place of Employment ____

Do you have Insurance? Yes / No (please circle) If so, Insuring Company ______________________

Policy#/Plan # ______________________ Subscriber ID ______________________

*****How did you hear about us?** *Be Specific:* ______________________________________

OFFICE POLICY (please initial each line)	**Initials**
1) Your appointment times are set aside especially for you. If you are unable to keep your appointment, no charge will be issued providing you give the office **2 business days notice**	
2) Any difference in cost that your insurance does NOT cover is expected at the end of each visit. Donly Dental accepts Cash, Cheque, Debit, Visa, or MasterCard.	

Medical History- ***Your assistance in completing this form in FULL will assist in giving you the safest quality medical and dental care.***

	Yes	No
Are you taking any pills or medication? What for? ______________________ Please specify ______________________________________	☐	☐
Are you on any blood thinners? If so, which one(s)? ______________________	☐	☐
Do you bleed easily from a cut or injury? If yes, how long to clot? ______________	☐	☐
Are you a hemophiliac? Type: ______________________________	☐	☐
Any artificial heart valves, infective endocarditis, or any heart condition? Specify: ________	☐	☐

Please Turn Over →

Question	Yes	No
Do you have rheumatoid arthritis, lupus, or any immune-suppression? Specify______________	☐	☐
Are you Diabetic? ***Type 1 or Type 2.*** Last blood glucose taken?_________________Blood glucose value:_______	☐	☐
Are you Asthmatic? Circle*: Mild / Moderate / Severe.* Last attack:______________________	☐	☐
Any allergies (eg Latex)? ____ What happens to you when you are exposed?____	☐	☐
Any unusual reaction to any medications or injection? (eg. penicillin, antibiotics, Advil, codeine, dental freezing?)_____________________________	☐	☐
Have you had hip, knee, or any other **joint replacement** surgery *(circle)*? Year? ___________	☐	☐
Have you ever been advised to take antibiotics before dental treatment?Why?:______________	☐	☐
Have you ever had hepatitis, HIV/AIDS, or any infectious disease? Specify:_______________	☐	☐
Have you had radiation or chemotherapy? When________________ Type________________	☐	☐
Do you have epilepsy or seizures? Last episode_____________________________________	☐	☐
Do you or did you smoke? How many per day______________________________________	☐	☐
Recreational drugs? ____	☐	☐

Any other medical condition/issues not mentioned? Please specify__________________

WOMEN: Are you taking **birth control pills** □? Are you pregnant □ ? Breastfeeding □ ?

Dental History

Question	Yes	No
Have you been to the dentist in the last 2 years? ____________________________________ Who was your previous dentist?____	☐	☐
Are you unhappy with the appearance of your teeth? Please explain ____	☐	☐
Do you have any concerns about having dental treatment?___________________________	☐	☐
Have you ever had an upsetting experience in the dental office? ______________________	☐	☐
Have you had a complication occur in the dental office?______________________________	☐	☐
How often do you brush? ___________ times a day. Floss ___________times a week		
Is there a problem you would like treated immediately?Specify__________________________	☐	☐

Do you experience any of these (please circle):

sore gums or bleeding gums	popping or clicking jaw	gagging
loose teeth	loose dentures	lip biting
sensitive teeth	headaches	teeth grinding or clenching
bad breath	crooked teeth	mouth sores

CONSENT FOR TREATMENT

I, the undersigned, authorize the dentist to perform diagnostic procedures as maybe required to determine necessary treatment. I understand that responsibility for payment for the dental services for myself and my dependents is mine, and I assume responsibility for the fees associated with these services.
I certify that I have provided an accurate and complete medical and dental history.

Patient/Guardian signature ______________________________Date ______________________________