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FAMILY DENTISTRY

MEDICAL HISTORY UPDATE

First Name _____ Last Name_____ Birthdate _____

Address _____

Home Phone _____Cell_____Work_____Email_____

Preferred contact method: Phone ☐ E-mail ☐ Text ☐

DENTAL INSURANCE INFORMATION

Primary Insurance plan:

Company _____

Plan Number _____

Subscriber ID Number _____

Secondary Insurance plan (if applicable):

Company _____

Plan Number _____

Subscriber ID Number _____

MEDICAL HISTORY

In case of emergency, whom should we contact? (include Name, relationship, and best phone number to contact)_____

Name, Address & Phone Number of Family Physician and Specialists

_____

Preferred Pharmacy Information_____

Last time you saw your Physician_____ Reason_____

Are you being treated for any medical condition(s) at present or within the last year by a physician or medical specialist? Yes ☐ No ☐

Condition_____

Have there been any changes to your general health in the last 5 years? Yes ☐ No ☐

Please explain._____

_____

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Have you had any surgeries or hospitalization in the last 5 years? Yes ☐ No ☐

Please explain._____

_____

Please list all medications, non-prescription medications, herbal supplements or vitamins you are currently taking – please include dosage and frequency.

_____

_____

_____

Do you have any allergies or adverse reactions to medications, latex, food, etc.? Yes ☐ No ☐

Please list._____

Have you ever been instructed to take antibiotics prior to a dental visit? Yes ☐ No ☐

Please indicate reason._____

Do you use tobacco in any form (including vaping or e-cigarettes)? Yes ☐ No ☐

Please indicate type and frequency. _____

Do you use cannabis in any form? Yes ☐ No ☐

Please indicate type and frequency. _____

Do you regularly use any recreational drugs including alcohol? Yes ☐ No ☐

Please indicate type and frequency. _____

Have you ever been diagnosed with cancer? Yes ☐ No ☐

Please indicate type and location: _____

Have you had chemotherapy? Yes ☐ No ☐ Date of last treatment: _____

Have you had radiation therapy? Yes ☐ No ☐ Date of last treatment: _____

Are you pregnant or breastfeeding? Yes ☐ No ☐ Expected delivery date? _____

Do you wear glasses, contact lenses, or hearing aids? _____

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Please indicate if you have experienced any of the following conditions.

Condition	Never	Currently Have	History of	Date of last incident and details of medications/treatment required
Heart disease: Heart attack, heart failure, angina pectoris				
Pacemaker (indicate year placed)				
Congenital heart defect or heart murmur (specify)				
Heart Valve concerns/Artificial valves (indicate date placed)				
Infective Endocarditis				
Rheumatic Fever				
Congestive heart failure				
Blood pressure concerns (high or low)				
Use of anticoagulants (blood thinners)				
Stroke				
Anemia				
Blood disorder (ex. Hemophilia, von Willebrand's, thalassemia, etc.)				
Prolonged bleeding, bruising easily, slow healing (specify)				
Lung disease: emphysema, COPD, etc. (specify)				
Asthma or shortness of breath (specify)				
Sinus problems, hay fever or seasonal allergies (specify)				
Snoring or sleep apnea, CPAP use				
Diabetes: type I, type II (specify) Controlled? Yes/No				
Thyroid disease: hyper- or , hypothyroidism, (specify)				
Stomach concerns (ex. Ulcers, acid reflux, GERD) (specify)				
GI concerns (inflammatory bowel disease, diverticulitis, etc.)				

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Condition	Never Had	Currently Have	History of	Date of last incident and details of medications/treatment required
Liver Disease (jaundice, Hepatitis A, B, C, etc.) (specify)				
Kidney disease (specify)				
Arthritis, (osteo- or rheumatoid)				
Artificial joints				
Osteoporosis (please specify medications or injections)				
Cancer (please indicate type)				
Auto-immune conditions (ex. Lupus, etc.)				
Sexually transmitted diseases (herpes simplex, syphilis, chlamydia, HIV/AIDs, etc.)				
Steroid or hormone therapy				
Organ transplant				
Eye disease: glaucoma, cataracts, blindness (specify)				
Neurological conditions (cerebral palsy, multiple sclerosis, Parkinson's disease, etc.)				
Epilepsy, seizures, or fainting spells (specify)				
Paralysis				
Alzheimer's, dementia (specify)				
ADD/ADHD, Autism (specify)				
Clinical depression, anxiety, psychiatric treatment (specify)				
Drug or alcohol dependency (specify)				

Any other condition that was not mentioned above or anything else you would like us to know about you? (e.g. You don't freeze well)

_____

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DENTAL HISTORY

What brings you to our office? Do you have any immediate dental concerns?

_____

When was your last dental visit? What procedures were performed (ex. Exam, X-rays, filling, etc.)

_____

I routinely saw my dentist every:

3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Not routinely ☐

How nervous are you about dental treatment on a scale of 1 (low) to 10 (high)? _____

Have you ever had an unfavourable dental experience or complications resulting from dental treatment? _____

Please indicate any concerns or conditions that may apply to you:

☐ Bleeding Gums
☐ Bruxism (clenching/grinding)
☐ Cavity prone
☐ Difficulty with freezing
☐ Dry mouth
☐ Gag reflex
☐ Gum Recession
☐ Jaw joint concerns (TMD/TMJ)
☐ Nail biting or other habits
☐ Orthodontics – teeth shifting or alignment
☐ Periodontal (gum) disease
☐ Sensitivity

What is your oral care routine?

☐ Tooth Brushing — Frequency? _____ times per day
Fluoridated toothpaste? Yes ☐ No ☐

☐ Flossing/floss sticks — Frequency? _____ times per day

☐ Mouthrinse — Frequency? _____ times per day

☐ Other _____ — Frequency? _____ times per day

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PATIENT RELEASE

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I authorize the dentist and/or their licenced staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.

_____ _____

Signature Date

FINANCIAL POLICY

The patient assumes all financial responsibility for any dental treatment incurred. Patients are required to pay for their dental services, in full, on the day of treatment.

Our office is pleased to submit your insurance claim on your behalf electronically. We are also able to offer paper dental claim forms for any insurance plan that requires manual submissions.

All dental insurance plans are different and may not cover all dental services. Dental offices do not have access to your personal insurance information and cannot determine your level of coverage. If you are concerned about your insurance coverage, we are pleased to submit a predetermination on your behalf which can be accessed by the insurance policy holder electronically or via mail.

BOOKING POLICY

Your appointment time has been reserved specifically for you. If you are unable to keep your appointment, we ask you to be mindful of the fact that this time slot could be used by another patient in need of urgent treatment.

We ask for 48 hours' notice for any changes to your appointment. If you are unable to provide this notice, a fee of $50.00/hour of time scheduled will be applied to your account to compensate for lost time and inconvenience to our other patients and dental providers. Any patient who fails to attend multiple dental appointments may be dismissed from the practice.

I, _____ , have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of Patient or Legal Guardian Date