SEAWAY FAMILY DENTAL

MEDICAL HISTORY FORM - CONFIDENTIAL

PATIENT INFORMATION:

Name: Mr./Miss/Mrs./Ms./Dr. _____ Today's date: _____
Last First Middle initial day/month/year

Address: _____
Number Street Apt. City Province Postal Code

Date of Birth: _____ Health Card Number: _____ Expiry date: _____
day/month/year day/month/year

Phone (Home): _____ (Work): _____ ext:_____

(Mobile):_____ E-mail address: _____

Person responsible for account: Self/Other – Name: _____

Do you have a dental insurance plan? ☐ Yes ☐ No

Insurance Company: _____ Group Policy #: _____ ID #: _____

Employer Name: _____ Occupation: _____

Previous Dentist: _____ Family Physician: _____

In case of emergency, please notify – Name: _____

Relationship: _____ Telephone #: _____

Referred by: ☐ Another Patient ☐ Family ☐ Friend – Name: _____

☐ Yellow Pages Book/Internet ☐ Website/Internet ☐ Radio ☐ Flyer ☐ Other: _____

I hereby give my permission to Seaway Family Dental to send me e-mail and/or SMS Messages (commonly known as "text messages") regarding my dental matters at the e-mail address and/or telephone number(s) listed above:

☐ Yes ☐ No

MEDICAL HISTORY:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the entire form.

1. Are you in good health? ..... ☐ Yes ☐ No
2. Has there been any change in your general health in the past year?..... ☐ Yes ☐ No
   If yes, please explain: _____
3. Are you currently taking any medication, non-prescription drugs or herbal supplements of any kind? .....☐ Yes ☐ No
   Please specify any medications: _____
4. Do you have any allergies? (e.g. Penicillin, latex/rubber product) ..... ☐ Yes ☐ No
   Others please specify: _____
5. Have you ever had a peculiar or adverse reaction to any medicines or injections? ..... ☐ Yes ☐ No
   If yes, please explain: _____
6. Do you bleed or bruise easily? ..... ☐ Yes ☐ No
7. Do you have a heart problem of any kind? ..... ☐ Yes ☐ No
   Explain: _____
8. Have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? ..... ☐ Yes ☐ No
9. Have you ever been advised by your doctor to take antibiotics before dental treatment? ..... ☐ Yes ☐ No
10. Have you ever been exposed to Hepatitis or Jaundice? ..... ☐ Yes ☐ No
11. Women only: Are you pregnant or breast-feeding? ..... ☐ Yes ☐ No

12. Have you ever been hospitalized for any illness or operations? ..... ☐Yes ☐No
    Please explain: _____

Do you have or have you ever had any of the following? Please check those that apply.

☐ AIDS	☐ Dizziness	☐ Hip replacement surgery	☐ Stomach ulcer
☐ Anemia	☐ Epilepsy	☐ Knee replacement	☐ Stroke
☐ Arthritis/Rheumatism	☐ Excessive bleeding	☐ Kidney disease	☐ Thyroid problem
☐ Blood disease	☐ Hay fever	☐ Lung disease	☐ Venereal disease
☐ Cancer	☐ Head injuries	☐Mental disorder	☐ Diabetes
☐ High/low blood pressure		☐ Prosthetic heart valve	

Have you ever had any illness not included above? ..... ☐Yes ☐No

Please specify: _____

DENTAL HISTORY:

1. Have you ever had a dental examination with a full series of x-rays of your teeth and jaws? ..... ☐Yes ☐No
2. When was your last dental visit? ..... ☐Yes ☐No
3. Have you ever had any complications/problems with past dental treatments? ..... ☐Yes ☐No
   Please explain: _____
4. Have you ever had any problems/reactions to local anesthetic? ..... ☐Yes ☐No
5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other
6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously
7. Do your gums feel swollen or tender? ..... ☐Yes ☐No
8. Does food lodge between your teeth? ..... ☐Yes ☐No
9. Does your jaw crack, pop or grate when opened widely? ..... ☐Yes ☐No
10. Do you grind or clench your teeth? ..... ☐Yes ☐No
11. Reason for today's visit: ☐ Examination and cleaning? ☐ Emergency or specific problem? _____
    Other? _____

OFFICE POLICIES (Please Read):

We will help prepare insurance claim forms and assist in requesting reimbursements from insurance companies on behalf of our patients. Not all services may be covered by dental insurance and every plan has its own unique quirks and exceptions. We will do our best to help you clarify your plan. **However, it is the patient's responsibility to understand his or her own dental insurance benefits. Unless otherwise agreed upon, services are to be paid for at each visit as they are performed.**

Please help us in providing the very best of service by remembering that once you have made an appointment this time is reserved for you. Therefore, we require a minimum of **48 hours notice (2 business days)** if an appointment must be cancelled or rescheduled. **A fee may be charged for cancelled or missed appointment without sufficient notice.** Please note that insurance companies do not cover fees for broken appointments. Therefore such fees are the patient's responsibility.

I authorize Seaway Family Dental to perform all dental or diagnostic procedures agreed to be necessary or advisable, including x-rays, photographs, and the use of local anesthetic or other medications as indicated. I understand that if I miss an appointment or provide less than 48 hours notice to cancel or reschedule an appointment, I may be charged a cancellation fee. I assume full responsibility for fees associated with my dental treatment and those of my dependents. I have read and fully understand the above conditions of treatment and I accept my responsibility as a patient at this office.

_____ **Date:** _____
Signature of patient, parent or guardian

Dentist signature: _____ **Date:** _____