## Personal Information

Name: ____________________________________________________ M___ F ___
First Middle Last

Address: ________________________________________Post Code:_______________

Date of Birth: ____________ Employer: _____________Occupation:________________

Tel: Home: _______________ Business: _______________ Cell:___________________

Email: ______________________________________________________________________

Physician/Specialist:_______________________________ Tel: ____________________

Emergency Contact: ___________________Tel: ____________ Cell: _______________

Dental Insurance: insurer:_______________ Group: ___________ID: _______________

## Medical History

Your answers are for our records only and will be confidential.

1. Are you being treated for any medical condition or have you been treated or hospitalized for any illnesses or operations? If yes, please explain

______________________________________________________________________

2. When was your last medical check-up? ______________________________________

3. Are you taking any medications? Please list: _________________________________

______________________________________________________________________

______________________________________________________________________

4. Do you have any allergies?

__ Medications (penicillin, local anesthetics, Asprin, etc.)

__Latex rubber products __Others (e.g. foods) ________________________________

5. Have you ever had a peculiar or adverse reaction to any medicines or injections?

______________________________________________________________________

6. Do you have any family history of diseases or medical problems?

______________________________________________________________________

7. Do you have any conditions or therapies that could affect your immune system, e.g

__Leukemia __AIDS __HIV infection __Radiotherapy ___Chemotherapy

8. Do you have or have you ever had heart problem or artificial joint?

___Artificial heart valve ___ Infection of the heart (i.e. infective endocarditis)
___Heart condition from birth ___Heart transplant ___Prosthetic / artificial joint

9. Do you have or have you ever had any of the following? Please check

__Asthma/hayfever __Angina/heart attack __Arthritis
__Bleeding problem __Hepatitis /liver disease __ Kidney disease
__High/Low blood pressure __ Shortness of breath __Diabetes
__Heart murmur/pacemaker __ Heart valve problem __Rheumatic fever
__Stomach ulcers __ Lung Disease __Stroke
__Seizures (epilepsy) __Thyroid disease __Steroid/ cortisone
__Drug/alcohol dependency __Osteoporosis medications (e.g. fosamax, actonel)
__Blood thinner (coumadin, aspin) Others:________________________

10. Do you smoke or chew tobacco products? Yes No

11. For women only: Are you breastfeeding or pregnant? When is the expected due date?

______________________________________________________________________

## Dental History

1. Have you had any allergic reaction to "freezing", difficult extractions or prolonged bleeding after extraction in the past? If yes, please explain

______________________________________________________________________

2. Have you had dental radiographs (X-ray)? If yes, when?

______________________________________________________________________

3. When did you have your last dental visit or hygiene care (dental cleanings)?

______________________________________________________________________

4. What reason for you being in this office today?

______________________________________________________________________

## Informed Consent/General Release

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I consent to my physician being contacted if necessary. I agree, in accordance with the rules of the Privacy Act, your office may collect, use and disclose my personal information as required, I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as may be necessary, I also understand that I assume responsibility for any and all fees associated with these procedures and services provided to me or my dependents.

**Signature: ______________________________ Date: ____________**