ROCKCLIFFE DENTAL & DENTURE CENTRE

681-A Montreal Rd, Ottawa, Ontario K1K 0T1

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: _____

Relationship: _____

Day Time Phone: _____

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

Mr - Mrs - Miss - Ms – Dr (please circle)

Name: _____

Date of Birth: _____ **OHIP #:** _____

Street: _____

City: _____ **Prov:** _____ **Email:** _____

Postal Code: _____

Home Phone:_____ **Mobile:** _____

Business: _____

We appreciate referrals. Whom may we thank for referring you or how did you learn about our office?

Patient: Name_____ **Doctor: Name**_____

___Web Site ____Yellow Pages ____ Location ____other: _____

Name of Family Physician: _____

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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why
_____ □ yes □ no □ not sure/maybe

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain. □ yes □ no □ not sure/maybe
_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
_____ □ yes □ no □ not sure/maybe

5. Do you have any allergies? If you answered yes, please list. □ yes □ no □ not sure/maybe
_____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes please explain. □ yes □ no □ not sure/maybe
_____

7. Do you have or have you ever had asthma? □ yes □ no □ not sure/maybe

8. Do you have or have you ever had any heart or blood pressure problems? □ yes □ no □ not sure/maybe

9. Do you have or have you ever had a heart murmur, mitral valve prolapse, or rheumatic fever? □ yes □ no □ not sure/maybe

10. Do you have a prosthetic or artificial joint? □ yes □ no □ not sure/maybe

11. Have you ever been advised by your doctor to take antibiotics before dental treatment? □ yes □ no □ not sure/maybe

12. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? □ yes □ no □ not sure/maybe

13. Have you ever had hepatitis, jaundice or liver disease? □ yes □ no □ not sure/maybe

14. Do you have a bleeding problem or bleeding disorder? □ yes □ no □ not sure/maybe

15. Have you ever been hospitalized for any illness or operation? If yes please explain. □ yes □ no □ not sure/maybe

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

□ chest pain, angina □ shortness of breath □ pacemaker □ steroid therapy □ seizures (epilepsy) □ arthritis
□ drug/alcohol dependency □ heart attack □ stroke □ prosthetic heart valve
□ lung disease □ tuberculosis □ cancer □ diabetes □ stomach ulcers □ thyroid disease
□ diet pill therapy □ kidney disease

17. Are there any conditions or diseases not listed above that you have or have had? If so, what? □ yes □ no □ not sure/maybe

18. Are there any diseases or medical problems that run in your family? □ yes □ no □ not sure/maybe

19. Do you smoke or chew tobacco products? □ yes □ no

20. Are you nervous during dental treatment? □ yes □ no □ not sure/maybe

21. Women only: are you breast-feeding or pregnant? If pregnant what is the expected delivery date? □ yes □ no □ not sure/maybe

Dental History

1 Are you having discomfort at this time? _____ Yes no
If yes please specify_____
2. Previous Dentist _____Last visit_____
3. Have you ever had a problem with local or general anesthetic? Yes no
4. Would you be interested in improving the appearance of your teeth? Yes no

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Do you currently experience?

___Loose teeth ___ Bleeding gums ___ sore gums
___Sensitive teeth ___ Bad breathe ____Popping or clicking in the jaw joints
___Missing teeth ___Headache ___ Spaced/or crooked teeth
___Unsatisfactory dentures

Insurance Information

Policy holder Insurance Information:

Name of policy holder_____
Date of birth_____
Name, Insurance Co_____Policy#_____
Certificate/ ID Number_____
Place of Employment_____

Are you claiming from more than one insurance company?

Yes No
If yes, complete the following

Name of policy holder_____
Date of birth_____
Name, Insurance Co _____Policy#_____
Certificate /ID Number_____
Place of Employment_____

Other than the policy holder(s) above, Indicate patient's name and relationship to insurance policy Holder by encircling the following ….

Patient's name_____ Spouse or Dependent
Patient's name_____ Spouse or Dependant
Patient's name _____Spouse or Dependant

CONSENT

To the best of my knowledge, the above information is correct.

I, _____,Consent TO THE PERFORMING OF THE DENTAL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE FOR MYSELF & FAMILY MEMBERS.

I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THESE PROCEDURES. I AUTHORIZE RELEASE, TO MY INSURER / PLAN ADMINISTRATOR, THE INFORMATION CONTAINED IN CLAIMS AND ESTIMATES MAILED OR SUBMITTED ELECTRONICALLY BY ROCKCLIFFE DENTAL & DENTURE CENTRE.

Patient/parent/guardian signature_____Date:_____

Dentist Signature_____Date_____