DENTISTRY ON SINCLAIR

Medical History

Patient ID#	

Medical Alert

Name: _____ Date of Birth _____ Date: _____
Day Month Year

Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Would you like office updates to be sent via email? Yes No Email: _____

Occupation: _____ Sex: _____ Marital Status: _____

How did you hear about us? _____ If referred by someone, please provide their name: _____

Family Physician: _____ Medical Specialist: _____

Previous Dentist: _____ Do you have dental insurance: _____ Yes No

In case of emergency please notify: _____ Relationship: _____ Phone: _____

Closest family relative: _____ Phone: _____ Spouse/Parents: _____

Children/Siblings: _____

Health History

1. Are you being treated for any medical conditions at present or within the past 2 years?_____ Yes No
If yes, please explain_____

2. Have you been hospitalized in the past two years?_____ Yes No

3. Have you recently or are you presently taking PRESCRIPTION or NON-PRESCRIPTION drugs? _____ Yes No
If yes please list:

1._____ (_____)

2. _____ (_____)

3._____ (_____)

4. _____ (_____)

5._____ (_____)

6. _____ (_____)

7._____ (_____)

8._____ (_____)

4. Have you ever reacted adversely to any of the following: (Please circle): ANTIBIOTICS – Penicillin, Sulfonamide, other antibiotics, ASPIRIN, BARBITUATES (sleeping pills) CODEINE, DARVON, LOCAL ANAESTHETIC (freezing), NITROUS OXIDE, any other medicine: _____ Yes No

5. Have you ever been advised against taking any specific type of medicine? _____ Yes No

6. Do you have any of the following: Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin rashes, Hives or any other allergic conditions? _____ Yes No

7. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?_____ Yes No

8. Do your ankles, feet or hands swell?_____ Yes No

9. Has your weight, appetite or energy level changed dramatically recently? _____ Yes No

10. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?_____ Yes No

11. Do you have any hearing difficulties?_____ Yes No

12. Do you smoke or use any form of tobacco? If yes, how much?_____ Yes No

13. Are you alcohol and/or drug dependant? _____ Yes No

and have you received treatment? _____ Yes No

14. **WOMEN ONLY**: Are you pregnant or suspect you may be?_____ Yes No

if yes, what month? _____

15. **WOMEN ONLY:** Are you taking any birth control pills?_____ Yes No

16. Is there anything else about your health we should be made aware of? _____ Yes No

17. Do you wish to speak to the doctor privately about any problem or medical condition? _____ Yes No

18. Indicate which of the following you presently have or ever have had:

A.I.D.S./HIV	Yes	No	Glaucoma	Yes	No	Malignant hyperthermia	Yes	No
Anemia	Yes	No	Head/neck injuries	Yes	No	Mental/nervous disorder	Yes	No
Angina pectoris	Yes	No	Heart disease/attack	Yes	No	Mitral valve prolapse	Yes	No
Arthritis/Rheumatism	Yes	No	Heart murmur	Yes	No	Organ transplant/implant	Yes	No
Artificial heart valve	Yes	No	Heart pacemaker	Yes	No	Psychiatric treatment	Yes	No
Artificial joints(hip/knee)	Yes	No	Heart rhythm disorder	Yes	No	Rheumatic/Scarlet fever	Yes	No
Blood disorders	Yes	No	Heart surgery	Yes	No	Sexually transmitted disease	Yes	No
Bronchitis	Yes	No	Hepatitis A, B, C ____	Yes	No	Sickle cell disease	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Sinus trouble	Yes	No
Circulation problems	Yes	No	Hodgkins disease	Yes	No	Stroke	Yes	No
Congenital heart lesions	Yes	No	Hyper/Hypo glycemia	Yes	No	Thyroid disease	Yes	No
Cortisone/steroid	Yes	No	Hypertension	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Jaundice	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Kidney disease	Yes	No	Other _____	Yes	No
Epilepsy or seizures	Yes	No	Liver disease	Yes	No	Other _____	Yes	No
Fainting or dizzy spells	Yes	No	Lung disease	Yes	No	Other _____	Yes	No
Glandular disorders	Yes	No	Lupus	Yes	No	Other _____	Yes	No

NO TO ALL THE ABOVE (section 18) ☐

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and will assume responsibility for all fees associated with these procedures.

Patient Name: _____

Patient (Parent, Guardian*) Signature: _____

If parent, guardian*, please print name: _____

Date:_____
Month Day Year

***Guardian of child or Guardian of adult under Guardianship**

DENTISTRY ON SINCLAIR

Dental History

Patient ID#	

Patient Name: _____ **Date:** _____

Is there a problem you would like treated immediately? _____ Yes No

Date of your last dental visit: _____ Last cleaning: _____ Last x-rays: _____

1. Have you ever had any of the following?

Periodontal treatment (treatment of the gums) When? _____ Yes No
Orthodontic treatment (to straighten or realign teeth) _____ Yes No
Oral Surgery (implants, wisdom teeth extracted, jaw surgery) _____ Yes No
Nightguard _____ Yes No

2. Are there any growths or sore spots in your mouth? _____ Yes No

3. Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums? ____ Yes No

4. Have you noticed any loose teeth, or have any of your teeth shifted? _____ Yes No

5. Does food catch between your teeth? _____ Yes No

6. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____ Yes No

7. Have you been advised to take antibiotics before a dental appointment? _____ Yes No

8. Do you use dental floss, proxabrush or stimudents? How often? _____ Yes No

9. How often do you brush your teeth? _____ Do you feel you have bad breath? _____ Yes No

10. Have you ever experienced any problems with your jaw or joints? _____ Yes No

11. Do you have any of the following habits?

Clenching or grinding _____ Yes No
Biting your cheeks or lips _____ Yes No
Mouth breathing _____ Yes No

12. Are you unhappy with the appearance of your teeth? _____ Yes No

13. What would you like to see changed? _____

14. Have you ever had an upsetting experience in a dental office? _____ Yes No

Patient Name: _____

Patient (Parent, Guardian*) Signature: _____

If parent, guardian*, please print name: _____

Date:_____
Day Month Year

***Guardian of child or Guardian of adult under Guardianship**

DENTISTRY ON SINCLAIR

Office Policy/Privacy Statement

Please help to maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore *you must give us 2 business days notice if a change to your appointment is absolutely necessary*.

Dentistry on Sinclair is a fee for service office. *You are personally responsible for your account and payment is expected in full at each visit as services are provided*.
Methods of payment accepted are: Cash, Visa Master Card and Interact/Debit.

Regarding Dental Insurance: As a courtesy, if your carrier allows, we will file claims and estimates on your behalf with your insurance company. Please understand that your dental insurance is based on a contract between, you, your employer and your insurance company and due to the Privacy Act, dental insurance companies will not give information to dental offices. Should you have any questions regarding your dental insurance benefits it is best for you to contact your employer or the insurance company directly, however, we will do everything we can to help you understand the information provided to you.

I authorize release to my dental benefits plan administrator, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes the same.

I acknowledge that your office has a Privacy Policy, and I can ask to see the Policy at any time. I agree that your office can use my information as set out in your office Privacy Policy

Patient Name: _____

Patient (Parent, Guardian*) Signature: _____

If parent, guardian*, please print name: _____

Date:_____
Month Day Year

***Guardian of child or Guardian of adult under Guardianship**