

Confidential Medical Form

Personal Information

Last name: _____ First name: _____ Sex: F M

Address: _____ City: _____ Postal code: _____

Home telephone No: _____ Work telephone No: _____ Ext: _____

Cell: _____ E-mail: _____ Birth date (MM/DD/YYYY): _____

Medicare Card No: _____ Expiry: Year: _____ Month: _____

Social Insurance No. (optional): _____

If you are less than 18 y-o, indicate name of parent/guardian: _____ Parent or Guardian

In case of emergency call: _____

Reason for visit: _____ Referred by: _____

Medical History

Weight: _____ Height: _____ Are you currently under the care of a physician? yes no

If so, reason: _____

Physician's name: _____ Physician's Telephone No: _____

Are you currently taking or have you taken any medication in the last six months? yes no

If yes, please describe them: _____

Are you presently taking natural or homeopathic products? yes no Specify: _____

Are you taking birth control pills? yes no Hormones? yes no Specify: _____

Did you have a weight loss or gain lately? yes no

Are you pregnant? yes no Are you breastfeeding? yes no

Do you or have you ever had any of the following:

Heart disease yes no Rheumatic fever yes no

Hemophilia yes no Prolonged bleeding yes no

Clear blood yes no Anemia yes no

Other blood problems? _____

High or low blood pressure: Normal Low High

Frequent colds or sinusitis yes no Tuberculosis or lung problems yes no

Digestive problems yes no Specify the digestive problem: _____

Stomach ulcers yes no Liver problems (hepatitis A, B, C or cirrhosis) yes no

Kidney problems yes no Do you urinate often? yes no

Sexually transmitted infections yes no Diabetes yes no

Thyroid problems yes no Skin disease yes no

Vision problems yes no Arthritis yes no

Osteoporosis yes no Do you take biphosphonates? yes no

Epilepsy yes no Nerve problems yes no

Mental illness yes no Specify the illness: _____

Frequent headaches yes no Dizziness or fainting yes no

Earaches yes no Hay fever yes no

Asthma yes no Do you smoke? yes no sometimes

Have you ever had radiation treatments or chemotherapy? yes no Do you have AIDS? yes no

Have you tested positive for AIDS? yes no Do you have any artificial joints? yes no

Do you snore or have you ever been told that you snore? yes no

Have you ever had an allergic reaction to any of the following:

Foods	<input type="radio"/> yes <input type="radio"/> no	Latex	<input type="radio"/> yes <input type="radio"/> no	Penicillin	<input type="radio"/> yes <input type="radio"/> no
Aspirin	<input type="radio"/> yes <input type="radio"/> no	Iodine	<input type="radio"/> yes <input type="radio"/> no	Sulpha drugs	<input type="radio"/> yes <input type="radio"/> no
Codeine	<input type="radio"/> yes <input type="radio"/> no	Local anesthetic	<input type="radio"/> yes <input type="radio"/> no	Other antibiotics	<input type="radio"/> yes <input type="radio"/> no

Other products, please specify: _____

Do you use drugs? yes no

Do you drink alcohol? No/A little In Moderation A lot

Have you ever been hospitalized or had surgery other than dental? yes no

If yes, specify the type of surgery and when? _____

Do you fear dental treatments? yes no

Do you wish to discuss your health privately with your dentist? yes no

Comments:

Dental History

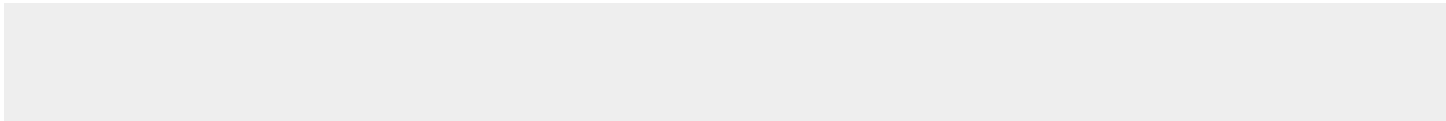
Date of last dental visit: 0-6 months 6-12 months + than 12 months

Treatment received: _____

Have you had any of the following dental treatments or services?

Oral hygiene demonstration	<input type="radio"/> yes <input type="radio"/> no	Gum treatment	<input type="radio"/> yes <input type="radio"/> no
Orthodontic treatment (braces)	<input type="radio"/> yes <input type="radio"/> no	Root canal treatment	<input type="radio"/> yes <input type="radio"/> no
Fillings	<input type="radio"/> yes <input type="radio"/> no	Crown(s) or bridge(s)	<input type="radio"/> yes <input type="radio"/> no
Full or partial dentures	<input type="radio"/> yes <input type="radio"/> no	Dental surgery or extraction	<input type="radio"/> yes <input type="radio"/> no
Dental implants	<input type="radio"/> yes <input type="radio"/> no	Dental X-rays	<input type="radio"/> yes <input type="radio"/> no
Others	<input type="radio"/> yes <input type="radio"/> no		

For professional use only:



RESERVED FOR DENTIST'S USE

I acknowledge that I have read the answers in the registration questionnaire and that I have taken the customary measures, as applicable.

Signature: _____ Date: _____

I, the undersigned, hereby declare that I have read, understood, informed myself about and answered the medical-dental questionnaire to the best of my knowledge. I hereby promise to inform you of any change in the state of my health. I authorize the creation of my dental chart, its follow-up, as well as my registration on the recall list of the attending dentist(s). I have been informed that my chart will be kept in the office at all times and that only the dentist(s) and his/her (their) support staff will have access to it. I have also been informed of my right to consult my chart, to request that it be corrected and to remove my name from the recall list.

Signature: _____ Date: _____