

Oakville Lane Dental

153 Hampton Road | P.O. Box 4784 • Rothesay, NB E2E-5X5

(506)849-3322

Medical & Dental History Form

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ * _____ * _____
Last First MI Preferred Name

Title: _____ Gender: * Male Female Family Status: * Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: * _____ Prev. Visit: _____ Email Address: _____

Phone: _____ * _____ _____ _____ Best time to call: _____
Home Mobile Work Ext

Address: _____ * _____ * _____ *
Address 1 Address 2
City PV Postal Code

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? Yes No

Within the past year, have there been any changes in your general health? Yes No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- Have you ever had complications following dental treatment?
- Are you currently under the care of a physician due to a specific condition?
- Have you been hospitalized within the last 5 years due to a surgery or illness?
- Are you currently taking any prescription or non-prescription medications?
- Do you use tobacco (smoking or chewing)?
- Do you require the use of corrective lenses (contacts or glasses)?
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant? Yes No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> *Pre-Medication | <input type="checkbox"/> *See Patient Chart | <input type="checkbox"/> Acetaminaphen | <input type="checkbox"/> Allergy - *See Notes |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Penicillin |
| <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Allergy-Erythromicin | <input type="checkbox"/> Allergy-Local Anesth | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Band-Aid Adhesive | <input type="checkbox"/> Bleeding/bruising | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Contraceptive Use | <input type="checkbox"/> Dementia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gastro-Intestinal |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hard To Freeze | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Hearing Disabled |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV+ (AIDS) |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> odine | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> STD | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> TMJ | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Wheelchair | | |

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist?

Please mark any of the following to indicate Yes in response to the question:

- Do your gums bleed when you brush or floss?
- Do your teeth experience sensitivity to cold or hot temperatures?
- Are any of your teeth currently causing you pain?
- Do you grind your teeth (either consciously or during sleep)?
- Are any of your teeth loose, or are you concerned about any teeth loosening?
- Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ Date _____

Relationship to Patient:

Response Date: _____