MEDICAL AND DENTAL HISTORY

Date: _____

Name : _____

Address: _____

City: _____ Province : _____ Postal Code : _____

Home Phone : _____ Business Phone : _____

Please indicate the phone number where we have permission to contact : _____

Birthdate : _____

Place of Employment : _____ Position/Title : _____

Please circle one : single married widowed separated divorced

IF MARRIED : (for contact information) Spouse's Name : _____

Place of Employment : _____ Spouse Business Phone : _____

Closest Relative not living with you: _____ Phone : _____

REFERRED BY :

Doctor (name): _____ Patient (name) : _____

Staff : _____ Sign : _____ Yellow Pages : _____

DENTAL INSURANCE INFORMATION:

Insured's Name : _____ Insured's Employer: _____

Insurance Company : _____

MEDICAL HISTORY

Your answers are for our records only, and will be considered confidential.
These facts have a direct bearing on your dental health.

Sex : _____ Age : _____

Name of Physician : _____

Address of Physician: _____

Date of last physical examination : _____

For the following questions, circle yes or no, whichever applies.

1. Are you in general good health?..... Yes No
2. Has there been any change in your general health within the year?..... Yes No
3. Are you now under a physician's care?..... Yes No
   If yes, for what condition?
4. Have you had any serious illness or operation?..... Yes No
   If so, please list:
5. Have you been hospitalized or had a serious illness within the past 5 years? Yes No
   If yes, what reason?

Cardiovascular system

1. Do you have or have you ever had any of the following (please circle): None
   Heart trouble Heart attack Stroke
   Damaged heart valves Congenital heart disease Coronary insufficiency
2. Rheumatic heart disease or Heart murmur?..... Yes No
3. Chest pain after exertion?..... Yes No
4. Do you have a cardiac pacemaker?..... Yes No
5. Do you have any blood pressure problems?..... Yes No
   High_____ Low_____

Central Nervous system

1. Do you have or have you ever had:
   a. Epilepsy?..... Yes No
   b. Fainting Spells?..... Yes No
   c. Seizures?..... Yes No
   d. Emotional disturbances?..... Yes No
2. Do you follow any treatment for a nervous disease?..... Yes No

Respiratory system

1. Do you have or have you ever had Tuberculosis?..... Yes No
2. Is there any history of Tuberculosis in your family?..... Yes No
3. Do you have any sinusitis or sinus trouble?..... Yes No
4. Do you have Emphysema, Chronic Bronchitis or Asthma?..... Yes No

Digestive system

1. Do you have any stomach ulcers?..... Yes No
2. Do you have or have you ever had:
   a. Hepatitis?..... Yes No
   b. Jaundice?..... Yes No
   c. Liver Disease?..... Yes No

Endocrine system

1. Do you have Diabetes?..... Yes No
2. Do you have Hypothyroidism?..... Yes No
3. Do you have Hyperthyroidism?..... Yes No

Hematopoietic system

1. Do you have Anemia, Sickle cell disease or any Blood disorders?..... Yes No
2. Are you hemophilic?..... Yes No
3. Have you had abnormal bleeding after any surgery, extraction or trauma?.. Yes No
4. Have you ever had a blood transfusion?..... Yes No

Allergies

1. Are you allergic to or have you acted adversely to:
   a. Local Anaesthetics?..... Yes No
   b. Antibiotics, Penicillin, or Sulpha drugs?..... Yes No
   c. Barbiturates, sedatives, or sleeping pills?..... Yes No
   d. Aspirin?..... Yes No
   e. Codeine or other narcotics?..... Yes No
   f. Other?..... Yes No
2. Do you have Asthma or Hay Fever?..... Yes No
3. Do you have or have you ever had Hives or Skin rash?..... Yes No

   If answered yes to any of the allergy questions, please provide more information:

Genitourinary system

1. Do you have or have you ever had kidney trouble? ..... Yes No
2. Have you been exposed to the HIV virus?..... Yes No
3. Do you have AIDS?..... Yes No

Bone and Joints

1. Do you have:
   a. Arthritis?..... Yes No
   b. Inflammatory Rheumatism?..... Yes No
   c. Bone Infection?..... Yes No
   d. Osteoporosis?..... Yes No

Neoplasms

1. Do you have or have you ever had:
   a. Tumor or malignancy?..... Yes No
   b. Chemotherapy or Radiation therapy?..... Yes No

Miscellaneous

1. Are you wearing, or do you wear contact lenses?..... Yes No
2. Do you drink alcohol?..... Yes No
   If yes, how much and how often?..... Yes No
3. Do you smoke or use tobacco?..... Yes No
   If yes, how much and how often?_____

Medications

1. Are you taking any of the following medications?
   a. Antibiotics or sulfa drugs?..... Yes No
   b. Anticoagulants (blood thinners)?..... Yes No
   c. Medicine for high blood pressure?..... Yes No
   d. Tranquilizers?..... Yes No
   e. Codeine or other Narcotics?..... Yes No
   f. Other?..... Yes No

If you are taking any medications, please give details of the name of the medication, the dose and frequency, and the reason for use:

_____

_____

_____

_____

_____

_____

Women

1. Are you pregnant?..... Yes No
2. Are you nursing?..... Yes No
3. Are you taking Oral Contraceptives or Hormonal Therapy?..... Yes No

DENTAL HISTORY

1. What is your chief complaint about your teeth?

_____

_____

_____

2. How would you like us to help you?

_____

_____

_____

3. Are you experiencing any discomfort or pain at this time?..... Yes No
4. Are you satisfied with the appearance of your teeth?..... Yes No
5. Are you able to eat and chew foods satisfactorily?..... Yes No
6. Do you have headaches, earaches or neck pain?..... Yes No
7. Do you have any problems with your jaw joints?..... Yes No
8. Do you have any problems with your bite?..... Yes No
9. Have you had serious trouble associated with previous dental treatment? Yes No
   If yes, please explain:

_____

Denture Patients

1. Do you wear partial or complete dentures?..... Yes No
   If yes, what do you have and when were they made?

2. Do your dentures move during function?..... Yes No
3. Do your dentures hurt?..... Yes No
4. Can you eat properly with your dentures?..... Yes No
5. Do your dentures drop and cause social embarrassment?..... Yes No
6. Are you satisfied with your facial appearance?..... Yes No
7. Are they satisfactory?..... Yes No
   Please expand on any problems and indicate any other denture concerns that you may have:

_____

Additional Information

Is there anything in your medical and dental history that we have not specifically asked about that we should be made aware of? If so, please explain:_____

_____

_____

_____

RESPONSIBILITY AND CONSENT FORM

I hereby authorize and request the performance of dental services for myself or for:

_____

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment.

These records may include study models, photographs and x-rays, which may be used for dental education and used in dental publications.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee.

I believe the information given in the six pages of this medical and dental history to be true to the best of my knowledge.

Signature of Patient or Guardian: _____

Signature of Doctor : _____

Date : _____

COVID-19 QUESTIONNAIRE

PATIENT DISCLOSURES:

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

X _____ X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* | **Witness** | **Date**

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgement

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* | **Date**