family DENTAL CARE Specialty

Our family keeps your family smiling

MEDICAL HISTORY FORM

Name:_____ Birthday: _____

Care Card #: _____ Phone number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Employer: _____ Occupation: _____

Emergency Contact:_____ Relationship: _____

Phone: _____

If undergoing sedation, who is responsible for taking you home? Name/Phone:

_____

Who is responsible for paying any cost not covered by insurance for this account?

_____

MEDICAL AND HEALTH CONDITIONS:

My last medical exam was on (approximate): _____

Are you currently under the care of a physician? ☐ YES ☐ NO

Name of your physician: _____

Have you been hospitalized within the past 5 years? ☐ YES ☐ NO

If yes, please explain why: _____

Are you currently taking any medication, prescription or non-prescription? Please list:

Drug: _____ Purpose: _____

Drug: _____ Purpose: _____

Drug: _____ Purpose: _____

DO YOU HAVE or EVER HAD:

Heart problems	☐ YES	☐ NO	Epilepsy or convulsions (seizures)	☐ YES	☐ NO
Heart murmur	☐ YES	☐ NO	Neurologic problems	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO	Viral infections and cold sores	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Any lumps or swelling in the mouth	☐ YES	☐ NO
Stroke	☐ YES	☐ NO	Hives, skin rash, hay fever	☐ YES	☐ NO
Artificial Prosthesis i.e heart valve/joint	☐ YES	☐ NO	Venereal disease	☐ YES	☐ NO
Anemia or other blood disorders	☐ YES	☐ NO	Hepatitis (type___)	☐ YES	☐ NO
Prolonged bleeding due to slight cut	☐ YES	☐ NO	HIV/AIDS	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Tumor, abnormal growth	☐ YES	☐ NO
Kidney disease	☐ YES	☐ NO	Do you need antibiotics prior to dental treatment? (told by physician)		
Jaundice	☐ YES	☐ NO		☐ YES	☐ NO
Liver Disease	☐ YES	☐ NO	Do you smoke?	☐ YES	☐ NO
Thyroid or parathyroid disease	☐ YES	☐ NO	Do you take any pills to strengthen your bones?	☐ YES	☐ NO
Hormone deficiency	☐ YES	☐ NO	Do you have any allergic reactions to a		
Diabetes	☐ YES	☐ NO	medication that we should be aware of?	☐ YES	☐ NO
Psychiatric Treatment	☐ YES	☐ NO	Do you have an allergy to :		
Osteoporosis i.e taking Bisphosphonate	☐ YES	☐ NO	Latex ☐ YES ☐ NO	Penicillin ☐ YES	☐ NO
Alcohol/Drug Dependency	☐ YES	☐ NO	Anesthetic ☐ YES ☐ NO	Metal ☐ YES	☐ NO
Stomach or duodenal ulcer	☐ YES	☐ NO	Strong family history of stroke/heart attack?	☐ YES	☐ NO
Digestive disorder i.e gastric reflux	☐ YES	☐ NO	Any other medical information we should know?		
Low blood pressure	☐ YES	☐ NO	_____		
Arthritis	☐ YES	☐ NO	WOMEN:		
Glaucoma	☐ YES	☐ NO	Are you taking birth control?	☐ YES	☐ NO

I, _____ do hereby consent to the release of dental/medical information, including records & X-rays to Family Dental Care. I authorize the release to my insuring company, the information contained in claims submitted electronically. I consent to the dental treatment agreed upon. I am responsible for payment of the corresponding fees at the date of service. I acknowledge that any fees NOT paid by my insurance company are my responsibility which may result in a separate bill after insurance pays the dentist & estimates are subject to change due to unforeseen treatment. I am aware that Family Dental Care will bill my insurance as a courtesy; however they are not responsible for my plan i.e: any limits & may not know my information due to the Privacy Act of B.C. I understand that a possibility of complications exists for each treatment.

In addition, 72 hours' notice is required for an appointment change otherwise a $100 rescheduling fee will apply.

I have carefully read and understand the terms and policies as described above.

Date: _____ Signature:_____