Milton GO DENTAL CENTRE

IMPLANT, COSMETIC & FAMILY DENTISTRY

Welcome!

Medical Alert ☐

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. **PLEASE PRINT.**

Patient Information

A parent or guardian will be responsible for decisions on my treatment: ☐ **Yes** ☐ **No**

Title: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Mst. ☐

Name: _____
First Initial Last Prefer to be called

Address: _____
Street Apt. # City Province Postal Code

Marital Status: _____ Date of Birth: _____/_____/_____ Email: _____
D M Y

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Driver's License No. _____ SIN _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Tel. (____) _____

Family Physician: _____ Tel. (____) _____

Medical Specialist: _____ Tel. (____) _____

Whom may we thank for referring you to our office? _____

If not referred, how did you choose our office? Google ☐ Yellow Pages ☐ Storefront Sign ☐ Facebook ☐ Other ☐ _____

Financial Information

Method of payment: Cash ☐ Credit Card ☐ Other ☐

Person responsible for account: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

IF DIFFER-ENT FROM ABOVE

Name: _____
First Initial Last

Address: _____
Street Apt. # City Province Postal Code

Date of Birth: ____/____/____ Home Phone (____) _____ Work Phone (____) _____
D M Y

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have provided is accurate and complete, and that I have not knowingly omitted any information. Should there be any change in my health status in the future, I will advise this dental office immediately. I consent to the release of medical information from or to my medical doctor or another health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ☐ Self ☐ Parent/Guardian Print name Date

Medical History

(This information will remain confidential.) Date _____

	YES	NO
1. Are you presently under the care of a physician? If so, explain. _____	☐	☐
2. Have you ever been hospitalized? Explain. _____	☐	☐
3. Are you taking any drugs or medication at this time (prescription or non-prescription, incl. herbal remedies)? -----	☐	☐

A) Drug _____ Reason _____ D) Drug _____ Reason _____

B) Drug _____ Reason _____ E) Drug _____ Reason _____

C) Drug _____ Reason _____ F) Drug _____ Reason _____

4. Have you ever had any adverse effect from any of the following: Antibiotics – Penicillin ☐ Sulphonamide ☐ Other ☐

Aspirin ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Darvon ☐ Local Anaesthetic ☐ NONE ☐.

5. Have you ever been warned against using any other medications? Which?_____	☐	☐
6. Have you ever taken prolonged medical or non-medical drugs? Which? _____	☐	☐
7. Do you suffer from any allergies (hay fever, metal or latex, etc.)? Which?_____	☐	☐
8. Do you bruise easily or have prolonged bleeding? ----------	☐	☐
9. Do you smoke? Did you smoke in the past? How much per day?_____For how many years?_____	☐	☐
10. Have you ever fainted or had shortness of breath or chest pains? ----------	☐	☐

11. **WOMEN:** Are you pregnant? Yes☐ No☐ Using birth control? Yes☐ No☐ Reached menopause? Yes☐ No ☐

12. Do you have or have you ever had any of the following? Please ✓ appropriate boxes. **NONE** ☐

☐ A.I.D.S.	☐ Cortisone/steroid	☐ High/Low Blood pressure	☐ Psychiatric disorders
☐ Anemia	☐ Diabetes	☐ H.I.V. Positive	☐ Radiation/Chemotherapy
☐ Angina pectoris	☐ Drug/alcohol dependence	☐ Hodgkin's disease	☐ Rheumatic/Scarlet fever
☐ Anorexia nervosa	☐ Emphysema	☐ Hyper (Hypo) Glycaemia	☐ Sickle Cell disease
☐ Artificial Heart valve	☐ Epilepsy or Seizures	☐ Hypertension	☐ Sinus trouble
☐ Arthritis/rheumatism	☐ Glandular disorders	☐ Jaundice	☐ Stomach/intestinal problems
☐ Artificial joints (hips, knees)	☐ Glaucoma	☐ Kidney disease	☐ Stroke
☐ Asthma	☐ Head/Neck injuries	☐ Liver disease	☐ Thyroid disease
☐ Blood disorders	☐ Heart disease/attack	☐ Leukemia	☐ Tuberculosis
☐ Bronchitis	☐ Heart murmur	☐ Lung disease	☐ Ulcers
☐ Bulimia	☐ Heart pacemaker/surgery	☐ Malignant hypothermia	☐ Venereal disease
☐ Cancer	☐ Heart rhythm disorder	☐ Mental/nervous disorder	☐ Other _____
☐ Circulation problems	☐ Hepatitis A/B/C	☐ Mitral valve prolapse	☐ Other _____
☐ Congenital heart lesions	☐ Herpes	☐ Organ transplant/implant	☐ Other _____

13. **CHILDREN** Have you had any of the following (indicate approximate date)?

☐ Chicken Pox _____ ☐ Measles _____ ☐ Mumps _____

☐ Strep Throat _____ ☐ Tonsillitis _____ ☐ NONE

Dental History

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other _____
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other _____
3. When was your last dental visit? _____ Last hygiene visit? _____ Last X-Ray? _____
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
5. Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Pressure ☐ Other _____
6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never

	YES	NO
7. Do your gums feel swollen or tender?----------	☐	☐
8. Do you have bad breath or a bad taste in your mouth?----------	☐	☐
9. Do your jaws crack, pop or grate when you open widely?----------	☐	☐
10. Do you grind or clench your teeth (day or night)? ----------	☐	☐
11. Do you have food catch between your teeth? ----------	☐	☐
12. Have you ever had local anaesthetic (freezing)? ----------	☐	☐
Any complications? Specify_____	☐	☐
13. Have you ever had any problems with previous dental treatments? Specify_____	☐	☐
14. Have you been advised to take antibiotics before a dental appointment?----------	☐	☐
15. Are you interested in sedation for your dental treatment? ----------	☐	☐

16. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps ☐ Implants

☐ Full or Partial Dentures ☐ Orthodontics (braces) ☐ Periodontal treatment/Gum Surgery ☐ Root Canals

17. Are you satisfied with your teeth? Specify_____	☐	☐

Thank You