Medical History

Name (Last) (First)

Preferred Name: Date of Birth (*dd/mm/yyyy*):

Home Address: City:

Province: Postal Code: Phone #:

Cell: Work: Employer:

Occupation:

In Case of Emergency Notify (Name): Relation:

Contact #:

The following is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Are you being treated for any medical condition presently or have been treated in the past year?

No

When was your last medical check up?

Don't know

Has there been any change in your general health in the past year?

No

If yes, please explain:

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

No

If yes, please list:

Do you have any allergies or serious reactions?

Don't Know

If yes, please list using categories below:

1. Medications:
2. Aspirin/Codeine:
3. Metals:
4. Anesthetic:
5. Sedatives/sleeping pills:
6. Latex/rubber products:

Other (please list):

Please indicate if you have or had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Bowel Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug/Alcohol Dependency
- ☐ Emphysema
- ☐ Gastrointestinal Disorder
- ☐ Glaucoma
- ☐ Hay Fever/Seasonal Allergies
- ☐ Heart Attack
- ☐ Heart Defects
- ☐ Heart Murmur
- ☐ Heart Palpitations
- ☐ Heart Trouble (chest pain)
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mistral Valve Prolapse
- ☐ Osteoporosis
- ☐ Rheumatic/Scarlet Fever
- ☐ Shortness of Breath
- ☐ Depression/Anxiety
- ☐ Jaundice
- ☐ Stroke
- ☐ Sinus Issues
- ☐ Skin Disorder
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Wheeze/Cough
- ☐ Pacemaker
- ☐ Steroid Therapy
- ☐ Fainting/Dizzy Spells
- ☐ Epilepsy (Seizures)

Any history of Sleep Apnea?
No
Are there any conditions or diseases not listed above you have or have had?
No
If yes, please explain:
Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (ie; infective endocarditis), a heart condition from birth (ie; congenital heart disease) or a heart transplant?
No
If yes, please indicate all that apply:
Do you have a prosthetic or artificial joint? No

Are there any diseases or medical problems that run in your family? (eg; diabetes or cancer)

Do you smoke or chew tobacco products?
No
Quantity per day
Quit
For women only: Are you breastfeeding or pregnant?
Both
If pregnant, what is the expected delivery date?

Dental History
Have you been under the regular care of a dentist?
No
Date of last visit:
Are you having any dental discomfort at this time? No

Have you ever been advised to take antibiotics before dental visits? Don't Know

Have you ever had a problem with local or general anesthetic? Don't Know

Do you have any emotional concerns about dental treatment? Sometimes

Are you nervous during dental treatment? Sometimes

Please indicate all that you are concerned about or currently have:

☐ Tooth pain/ache	☐ Gum disease	☐ Missing teeth	☐ Ugly teeth
☐ Sensitivity (hot/cold/sweets)	☐ Loose teeth	☐ Spacing	☐ Whiter teeth
☐ Pain to bite	☐ Recession	☐ Implants	☐ Crooked teeth
☐ Broken teeth	☐ Bleeding gums	☐ Inflamed gums	☐ Orthodontics
☐ Broken fillings	☐ Dry mouth	☐ Want to save teeth	☐ Cosmetic dentistry
☐ Cavities	☐ Bad breath	☐ Poor dentistry	☐ Gentle dentistry
☐ Jaw or face pain	☐ Headaches	☐ Clenching/grinding	☐ Clicking jaw
☐ Snoring/Sleep apnea	☐ Sedation dentistry		

How did you hear about us? Check all that apply:

- ☐ Convenient location (saw road sign/flags)
- ☐ Billboards/bus stop signs
- ☐ Received welcome letter/brochure in mail
- ☐ Facebook
- ☐ Google
- ☐ Google
- ☐ Referred by friend/family member.
  Who?

Other:

Office Policy: Your appointment time is reserved especially for you. We require 48 business hours notice if you are unable to keep the reserved time. Otherwise it may be necessary to charge for the lost time if insufficient notice is received. The fee will be determined by the dentist you have been scheduled with depending on the type of appointment. We understand and respect that your time is valuable as well, and will endeavor to see you at your reserved time.

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to my questions regarding my medical/dental history. I authorize the dentist to perform diagnostic procedures and treatment may be necessary. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted when necessary. I understand that responsibility for payment for the dental services for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

Insurance Policy: I understand that the fees listed for dental treatment may not be covered by or may exceed my dental benefits. I understand that I am financially responsible to my dentist for any balance owing. ***As a courtesy, we try and keep track of your policy contributions, but ultimately this is your responsibility.*** All estimates will be sent for you, but will be returned to you only. Please share with us the explanation of these estimates so we can also be aware of your coverage. As an additional courtesy, we offer direct billing and assignment of benefits (if allowed by your policy) to you insurance. This means sending the claims in directly to the insurance company and have them send the office the insurance cheque. If this method is preferred, please be aware that any unpaid portion is your responsibility and not the dental office and is to be paid by you.

Name of Patient:

Signature of Patient/Guardian: Date:

Signature of Reviewing Dentist: Date:

For office use (pick one):

ASA	Class I	Class II	Class III	Class IV
Malampatti	Class I	Class II	Class III	Class IV
Head& Neck mobility	Good	Poor		

KEMPTVILLE SMILES DENTISTRY

The best compliment is a referral!

If you enjoyed your visit here, please recommend us to your friends and family

Like us on Facebook *Review us on Google*