MEDICAL ALERT

Mr. ❑ Mrs. ❑ Miss. ❑ Ms. ❑ Dr. ❑ ❑ ADULT ❑ CHILD

Name: (Last) _____ (First) _____ (Initial) _____ Prefer to be Called: _____

Address: (Street) _____ (Apt.#) _____ (City) _____ (Postal Code) _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X _____ Date of Birth: ____ / ____ / ____ (MM / DD / YY)

Fax: (____) _____ - _____ Other: (____) _____ - _____ X _____ ❑ Male ❑ Female

Employer / School: _____ Occupation: _____

eMail ID: _____ Who may we thank for referring you to this office?: _____

Are you likely to be available on short notice for future appointments or appointment changes? ❑ Yes ❑ No

Family Physician: _____ Phone: (____) _____ - _____

In Case of Emergency Notify: _____ Relation: _____ Phone: (____) _____ - _____

Person responsible for this account: ❑ Self ❑ Spouse ❑ Parent ❑ Legal Guardian ❑ Other: _____

Name: (Last) _____ (First) _____ (Initial) _____ Relation: _____

Address: (Street) _____ (Apt.#) _____ (City) _____ (Postal Code) _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X _____ _____ Driver's Licence Number

Primary Insurance

Subscriber: _____

Relation: ❑ Self ❑ Spouse Other: _____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Subscriber I.D. _____ SIN _____

Are You Familiar With Your Plan Details? ❑ Yes ❑ No

Secondary Insurance

Subscriber _____

Relation: ❑ Spouse Other: _____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Subscriber I.D. _____ SIN _____

Are You Familiar With Your Plan Details? ❑ Yes ❑ No

Method of Payment ☐ Cash ☐ Cheque ☐ Credit Card: _____ Number: _____ Exp.: _____

MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

The following information is required by the dentist to assist in proper diagnosis and treatment.	YES	NO
1. Have you ever had a serious illness requiring hospitalization or extensive medical care?	❑	❑
Please specify: _____		
2. Are you presently under the care of a physician?	❑	❑
If so, please explain: _____		
3. Have you had a medical examination in the last year?	❑	❑
4. Do you use any prescription or non-prescription drugs regularly?	❑	❑
Please specify: _____		
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex?	❑	❑
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea?	❑	❑
Please specify: _____		
7. Have you been hospitalized in the last 5 years?	❑	❑
Please specify: _____		
8. Have you ever experienced any unusual reaction to any of the following? (Please circle)	❑	❑
local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? If so please explain _____		
9. Have you been warned against taking any drug or medication?	❑	❑
10. Do you bruise easily or bleed abnormally?	❑	❑

PATIENT REGISTRATION PLEASE COMPLETE BOTH SIDES **MEDICAL / DENTAL HISTORY**