FAIRVIEW FAMILY DENTAL

Name: _____

Date of birth (dd/mm/yyyy):_____ Health Card #: _____

Address: _____

City: _____Postal Code _____

Telephone (Home): _____ Telephone (Cell):_____

Family Doctor: _____ Phone: _____

Do you Have Insurance? (Please Circle) Cash Work plan HSO ODSP Ontario Works

Medical History

		Yes	No
1.	Have you ever had a serious illness requiring hospitalization or extensive medical care?	☐	☐
	_____		
2.	Do you have any drug or food allergies?	☐	☐
	_____		
3.	Have you been warned against any drug or medication	☐	☐
	_____		
4.	Do you take any medications? Please list below:	☐	☐
	_____		
	_____		
5.	Have you ever had a problem with local anesthetic (freezing)?	☐	☐
6.	Are you pregnant or nursing?	☐	☐

7. Do you have or have you had? (PLEASE CIRCLE)

Heart Disease	Heart Attack	Heart murmur	High/low Blood Pressure
Liver Disease	Diabetes	Chest Pain	Blood Disorders
Kidney Disease	Epilepsy	Stroke	Prolonged Bleeding
Cancer/chemotherapy	Anemia	HIV/AIDS	Thyroid Problems
Rheumatic Fever	Asthma	Hepatitis A/B/C	Stomach Ulcer
Cold Sores	Cortisone/Steroid	Tuberculosis	Sinus Trouble
Epilepsy/Seizures	Glaucoma	Emphysema	Lung Disease

Dental History

Reason for this visit _____

Last dental visit (date) _____ Treatment provided at that time_____ Frequency of dental visits_____ Previous dentist (name and location) _____ Have you had a complete series of dental films/x-rays taken? _____ Where? _____ When? _____ Can we request these be sent to this office? _____

Have you had: ☐ Braces ☐ Oral Surgery ☐ Gum Treatment ☐ Root Canal

Office Policy: You're appointment time will be reserved especially for you. We Require 48 hour notice, otherwise it may be necessary to change for the lost. **Patient Release**: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and 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 as may be necessary for proper dental care. I also understand the consultation with my medical doctor may be required, and I consent to my physician to being contacted if necessary. I understand that responsibility for payment for dental services provided for myself and my dependent is mine and I will assume responsibility for fees associated with these services.

Patient Signature (or Guardian):_____ Date: _____

DENTIST SIGNATURE: _____