PATIENT MEDICAL HISTORY

	YES	NO
1. Are you now under the care of a physician?		
What is the condition being treated?		
2. Have you had any serious illness or operation?		
If yes, what was the illness or operation?		
3. Are you taking any drug or medicine including birth control pills or herbal/organic supplements?		
If yes, what?		
4. Do you use tobacco products?		
Cigarettes ________ No. per day ___________ Pipe ________ Snuff ________		
Have you ever tried to eliminate these products from your life?		
5. Are you allergic to or have you reacted adversely to any drug or medicine: eg. local anaesthetic (freezing), penicillin or other antibiotics, barbituates, sedatives, analgesics (pain killers)?		
If so, what?		
6. Do you have any of the following?		
a. Rheumatic fever or rheumatic heart disease		
b. Birth defects in the heart		
c. Heart attack, high blood pressure, hardening of the arteries, stroke		
d. Chest pains or shortness of breath		
e. Asthma, hay fever or skin rash		
f. Fainting spells or seizures (epilepsy)		
g. Diabetes		
h. Kidney disease		
i. Hepatitis, jaundice or liver disease		
j. Thyroid disorder		
k. Lung or breathing disorder		
l. Stomach/bowel problems: eg. ulcers		
m. Nervous disorder		
n. Bone, muscle or joint disorders: eg. arthritis		
o. Cancer		
p. Aids or ARC HIV Positive		
7. Have you ever had abnormal bleeding associated with previous extractions, surgery or cuts?		
8. Do you have any blood disorder?		
9. Women, are you pregnant?		
10. Do you have any disease or disorder not listed that you think I should know about?		

If yes, what? ____________________

TREATMENT CONSENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable and will assume responsibility for the fees associated with those procedures.

Signature of patient (parent, guardian) ____________________ Date ____________________

PATIENT PERSONAL INFORMATION

Patient Last Name: ____________________

Patient First Name: ____________________

Patient Middle Initial: ________ Sex: M ___ F ___

Title: Mr. Mrs. Miss, Master, Ms. ____________

Marital Status: M _____ S ______ C.L. ______

Spouse or Partner's Name: ________________

Res. Phone: ______________________

Bus. Phone: ______________ Ext.: ________

Cell. Phone: ______________________

S.I.N.: __________________________

Birth Date: Month ___ Day ____ Year ______

Name of Physician: ____________________

Who may we thank for referring you?:

Person: __________________________

Yellow Pages: ______________________

Staff: __________ Other: ______________

Patient Mailing Address: ________________

____

City: ______________________________

Prov.: ___ Postal Code: ________________

If Child - Parent's Name: ________________

Policy Holder's Name: __________________

Policy Holder's Date of Birth: ____________

Policy Holder's S.I.N.: __________________

Name of Employer: _____________________

Insurance Company: ____________________

Group # _____________ Dependent #: _______

Basic ________ Crown & Bridge ____________

Ortho ______________________________

Is there a deductible? Yes _____ No _________

Indian Affairs Dental Coverage

☐ Yes ☐ No Status #: ________________

Have you seen a dentist this year?: Yes __ No __

Who?: __________________________ Care Card #: ________________________

If yes, what was done? ____

____

Dental Concerns: ____

____

____

____

Are you aware of our web site? Yes ___ No ____ Have you used our web site? Yes ____ No ____

www.vanderhoofdental.com

NOTE: If your insurance company will not pay for a procedure the responsibility is yours. The insurance contract is between the insured patient and the insurance company, not the dentist and the insurance company.